

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13551 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13538

Reg. Dist. No.

| | | | |
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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural) | | c. LENGTH OF STAY IN Byrs. 7 mos. 23 days Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital | | d. STREET ADDRESS 725 S. Bond Street | |
| 3. NAME OF DECEASED (Type or print) Mary. Smialkowski Anderson | | 4. DATE OF DEATH December 22, 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 27, 1893 |
| 9. AGE (in years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packing House Employee | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Stanislaus Krygier Louis Krager | | 14. MOTHER'S MAIDEN NAME Josephine Pilachowski Sophie Polaski | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Catherine Scardino Address 406 S. Wolfe Street | | Springfield State Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction with perforation of left ventricular wall. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis. [a], stating the underlying cause lost. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Unknown Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type. | | 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE James T. Marsh | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) James T. Marsh, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED December 22, 1958 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/26/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery | | 22d. LOCATION (City, town, or county) (State) 1300 Dundalk Ave, Balto, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George G. Weher ADDRESS 705 S. Ann st | | 24a. REC'D BY REGISTRAR 12/24/58 24b. REGISTRAR'S SIGNATURE Arthur S. Krane | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13552

CERTIFICATE OF DEATH

Reg. Dist. No.

13539

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| 1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 5yrs. 10mos. 186. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calx/Balto. Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 7908 Hillendale Road, Balto. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Blanche Vernon Archer | | | | 4. DATE OF DEATH Month Day Year December 1 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/12/75 | |
| 9. AGE (In years last birthday) 83 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | | | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME James Richard Archer | | | | 14. MOTHER'S MAIDEN NAME Mary Eliz. Hobbs | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Address Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular heart disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circulatory disturbance with psychotic reaction. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/20 , 19 54 , to 12/1/58 , 19 58 , that I last saw the deceased alive on 12/1 , 19 58 , and that death occurred at 9:40 a.m. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Edmund Lusthaus | | | | ADDRESS (Street, city or town, state) Springfield State Hospital | | | |
| DATE SIGNED 12/1/58 | | | | | | | |
| PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/4/58 | | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park | | 22d. LOCATION (City, town, or county) (State) Balto. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Liston Woodfield | | | | ADDRESS 500 E 22nd St | | 24a. REC'D BY REGISTRAR DEC 5 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hanes | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13553

CERTIFICATE OF DEATH

13540

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville (Rural)</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>301-4</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u> | | d. STREET ADDRESS <u>2002 Swansea Road</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Antoinette</u> Last <u>Beck</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>February 11, 1881</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Beck</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address <u>Springfield State Hospital Record</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>461X</u> (b) <u>Rheumatic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with disturbance of growth, metabolism or nutrition, with senile brain disease, with psychotic reaction.</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 1, 1957</u> , to <u>December 10, 1958</u> , that I last saw the deceased alive on <u>December 10, 1958</u> , and that death occurred at <u>7:25 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Rita S. Glahn</u> | | ADDRESS (Street, city or town, state) DATE SIGNED <u>12/10/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Rita S. Glahn, M.D.</u> | | <u>Sykesville, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-13-58</u> | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u> | 22d. LOCATION (City, town or county) (State) <u>Baltimore Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lernard J. Luck</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 15 '58</u> | |
| ADDRESS <u>3051 Hayford</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hirsch</u> | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

13554

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13541

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Mt. Airy</u> c. LENGTH OF STAY IN 1b | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson RD 1 10x-2</u> d. STREET ADDRESS <u>RURAL</u> | | |
| 3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>HERBERT</u> Middle <u>BELL</u> Last | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>13</u> Year <u>1958</u> | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-18-1932</u> | 9. AGE (In years last birthday) <u>26</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer-concrete</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> |
| 13. FATHER'S NAME <u>James Otis Bell</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mildred Fredericks</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>B14-28-2232</u> | 17. INFORMANT <u>Margaret E. Bell</u> Address <u>SAME</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Comp fracture Skull - Crushing</u> <u>816 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>injury to chest</u> DUE TO (c) <u> </u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>min</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Collision of M.V. with M.V.</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>12/13 1958</u> Hour <u>12:50</u> a. m. <u> </u> p. m. <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> | 20f. (City or town) <u>Redgville</u> | (County) <u>Cornell</u> | (State) <u>Md</u> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>James J. Marsh</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>12/13/58</u> | |
| EXAMINER'S NAME (Type) <u>JAMES T MARSH</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>12-16-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u> | 22d. LOCATION (City, town, or county) <u>Della-Fred. Co. Md.</u> | (State) <u> </u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u> | | ADDRESS <u>Frederick-Md.</u> | | 24a. REC'D BY REGISTRAR <u>DEC 22 58</u> | 24b. REGISTRAR'S SIGNATURE <u> </u> |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13547

CERTIFICATE OF DEATH

13542

Reg. Dist. No.

| | | | | | | | |
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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster | | | | c. LENGTH OF STAY IN 1b 6 weeks | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jordan's Convalescent Home | | | | e. STREET ADDRESS 509 Main Street | | | |
| 3. NAME OF DECEASED (Type or print) First Herbert Middle Newton Last Berryman | | | | 4. DATE OF DEATH Month December Day 14 Year 1958 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 13 1890 | | 9. AGE (In years last birthday) 68 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral director | | 10b. KIND OF BUSINESS OR INDUSTRY Self employed | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Berryman | | | | 14. MOTHER'S MAIDEN NAME Susan Elizabeth Worrell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 220-34-6042 | | 17. INFORMANT Address Oliver C Berryman Reisterstown Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - lobar - left lower 447X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) Hypertension | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days 2 years 2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1957 to December 14, 1958 , that I last saw the deceased alive on December 14, 1958 and that death occurred at 9:00 M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Clarence E McWilliams M.D. | | | | ADDRESS (Street, city or town, state) Reisterstown, Maryland DATE SIGNED Dec 15, 1958 | | | |
| PHYSICIAN'S NAME (Type) Clarence E McWilliams | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec 17 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | 22d. LOCATION (City, town, or county) (State) Pikesville MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Oliver C. Berryman | | | | 24a. REC'D BY REGISTRAR DATE DEC 22 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kline | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13213

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

13213

13213

Form with multiple lines for text entry, including fields for name, date, and other details. The form is oriented vertically and contains various labels and checkboxes.

13543

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

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| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | c. LENGTH OF STAY IN lb <u>3 months</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster 27</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>201 Sullivan Ave.</u> | | | d. STREET ADDRESS <u>201 Sullivan Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Max</u> Last <u>Beyer, Jr.</u> | | | 4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1958</u> | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 11, 1958</u> | | 9. AGE (In years last birthday) yrs. <u>3</u> Months <u>13</u> Days <u>13</u> Hours <u>Min.</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Hanover, Penna.</u> | |
| 13. FATHER'S NAME <u>Lawrence Max Beyer, Sr.</u> | | | 14. MOTHER'S MAIDEN NAME <u>Princess Dolly Taylor</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT Address <u>Lawrence Max Beyer, Sr.-Westminster, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>No Anatomical Cause of Death Found</u> <u>795.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Paul F. Guerin</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>12-24-58</u> | |
| EXAMINER'S NAME (Type) <u>Paul F. Guerin, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Dec. 27, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>European Memorial Cemetery</u> | |
| 22d. LOCATION (City, town, or county) <u>Clayton, Md.</u> | | 22e. (State) <u>Md.</u> | | 22f. (City or town) (County) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u> | | ADDRESS <u>Westminster, Md.</u> | | 24a. REC'D BY REGISTRAR <u>Arthur S. France</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u> | | DATE <u>DEC 29 '58</u> | | | |

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MISSISSIPPI STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STANDARD

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13555

CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAYBERRY RURAL</u> | | c. LENGTH OF STAY IN 1b <u>1 WEEK</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WESTMINSTER RURAL</u> | |
| f. STREET ADDRESS | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JESSIE M BIGHAM</u> | | 4. DATE OF DEATH Month Day Year <u>DEC 21 1958</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT 26-1883</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>WILLIAM BARNES</u> | | 14. MOTHER'S MAIDEN NAME <u>ANNIE MITTEN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>MRS ARTHUR DUVALL</u> | | Address <u>RURAL WESTMINSTER</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial degeneration</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 1/2 yrs</u> DUE TO (c) <u>Unknown</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Jan 2, 1955</u> to <u>Dec 21, 1958</u> that I last saw the deceased alive on <u>12-6-1958</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Kemper Ave Westminster MD</u> DATE SIGNED <u>12/21/58</u> | | | |
| ACTUAL SIGNATURE <u>E. Reese Wilkens</u> M.D. | | PHYSICIAN'S NAME (Type) <u>E Reese Wilkens</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>12/23/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL</u> | 22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W Hartzler & Sons New Windsor</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 24 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>W. H. Hartzler</u> |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

See Part 10

Place of Birth

Married

Place of Death

Place of Burial

Place of Interment

Place of Residence

Place of Birth

Place of Death

Place of Burial

Place of Interment

Place of Residence

Place of Birth

Place of Death

Place of Burial

Place of Interment

Place of Residence

Place of Birth

Place of Death

Place of Burial

Place of Interment

Place of Residence

Place of Birth

Place of Death

Place of Burial

4-22-12

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13557 CERTIFICATE OF DEATH

13546

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine | | c. LENGTH OF STAY IN 1b 11 Mo. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weitzel Nursing Home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3401-4 | |
| 3. NAME OF DECEASED (Type or print) JOSEPH SHEITON BRENIZE | | 4. DATE OF DEATH 12-20 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 28-1891 |
| 9. AGE (In years last birthday) 67 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Signal Man | | 10b. KIND OF BUSINESS OR INDUSTRY Penna. R.R. | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Brenize | | 14. MOTHER'S MAIDEN NAME Jennie Bailey | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 717-07-6260 | |
| 17. INFORMANT Nellie R. Brenize-1313 Asbury Rd. | | Address Baltimore 9. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest, Arteriosclerosis 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized, Chronic trophic lateral sclerosis DUE TO (c) Severe Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 1957 20 Dec 58 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1957 , 19 20 Dec , 19 58 , that I last saw the deceased alive on 20 Dec , 19 58 , and that death occurred at 8:30 M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Howard E. Hall M.D. | | ADDRESS (Street, city or town, state) Hyattsville, Md. DATE SIGNED 20 Dec 58 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-23-58 | |
| 22c. NAME OF CEMETERY OR CREMATOR Jessops Methodist Church - Baltimore | | 22d. LOCATION (City and county) (State) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frank W. Seitz | | ADDRESS 814 W. 36th, St. | |
| 24a. REC'D BY REGISTRAR DEC 22 '58 | | 24b. REGISTRAR'S SIGNATURE William S. Howard | |

1875

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

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|------------------------------------|--|--------------------------------------|--|--------------------------------------|--|
| NAME OF DECEASED JAMES H. KIRK | | SEX Male | | AGE 35 | |
| PLACE OF BIRTH Baltimore, Md. | | OCCUPATION Clerk | | COLOR White | |
| DATE OF DEATH Jan 10 1875 | | TIME OF DEATH 10:30 A.M. | | PLACE OF DEATH Home | |
| CAUSE OF DEATH Consumption | | PERIOD OF ILLNESS 6 months | | PRESENT DISEASE Consumption | |
| PREVIOUS DISEASES None | | MEDICAL ATTENDANCE Yes | | NAME OF PHYSICIAN Dr. J. H. Smith | |
| NAME OF FUNERAL HOME None | | NAME OF MINISTER Rev. J. H. Smith | | NAME OF CHURCH St. Paul's | |
| NAME OF BURIAL PLACE St. Paul's | | NAME OF CEMETERY St. Paul's | | NAME OF INTERMENT St. Paul's | |
| NAME OF REGISTRAR J. H. Smith | | NAME OF CLERK J. H. Smith | | NAME OF DEPUTY CLERK J. H. Smith | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13558 CERTIFICATE OF DEATH

13547

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY <u>Howard</u> <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>19 mos</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3001-4</u> d. STREET ADDRESS <u>337 S. Bentalou Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Edward E. Brooks</u> First Middle Last | | | | 4. DATE OF DEATH <u>December 27</u> <u>19 58</u> Month Day Year | | | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-30-1896</u> | | 9. AGE (In years last birthday) <u>61</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grain Hooker ... Crown Cork & Seal</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Maryland</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME <u>Robert M. Brooks</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Clara W. Ball</u> | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u> | | | | 16. SOCIAL SECURITY NO. <u>113-01-5363</u> | | | | 17. INFORMANT <u>Author O. Godman</u> | | | | Address <u>337 S. Bentalou Street</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema of lungs. Psychotic depressive reaction</u> | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I attended the deceased from <u>5-27</u> , 19 <u>57</u> , to <u>12-27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-26</u> , 19 <u>58</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Walter Knott</u> M.D. <u>Springfield State Hospital</u> PHYSICIAN'S NAME (Type) <u>WALTER KNOTT</u> <u>Sykesville, MD</u> <u>12-27-58</u> | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>Dec. 31-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | | | | 22d. LOCATION (City, town, or county) <u>Baltimore Maryland</u> (State) | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Support</u> ADDRESS <u>1300 Eutaw Place</u> | | | | | | | | | | | | 24a. REC'D BY REGISTRAR <u>DEC 29 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13549 CERTIFICATE OF DEATH

13548

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll New Windsor</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor, Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>F.</u> Last <u>Brown Sr.</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 31 1891</u> |
| 9. AGE (In years last birthday) <u>67</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco Mills</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Curtis H. Brown</u> | | 14. MOTHER'S MAIDEN NAME <u>Alice R. Handley</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Mrs. Annie Brown</u> | | Address <u>New Windsor</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>years</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12/1/56</u> , 19____, to <u>12/11/58</u> , 19____, that I last saw the deceased alive on <u>12/9/58</u> , 19____, and that death occurred at <u>1:15 P.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>M. E. Robertson</u> | | ADDRESS (Street, city or town, state) <u>New Windsor, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>M. E. Robertson</u> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-14-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Old Calverton</u> | | 22d. LOCATION (City, town, or county) (State) <u>Sevier Co. Carroll Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hughes</u> | | ADDRESS <u>Sevier Co. Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>DEC 17 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE ONE 18

1954

| | | | | | |
|----------------------------------------------------------|--|--------------------------------------------|--|--------------------------------------------|--|
| NAME OF DECEASED JAMES EARL RAY | | SEX MALE | | AGE 35 | |
| DATE OF BIRTH JANUARY 5, 1919 | | PLACE OF BIRTH MOBILE, ALABAMA | | RACE WHITE | |
| DATE OF DEATH APRIL 4, 1968 | | PLACE OF DEATH MEMPHIS, TENNESSEE | | TIME OF DEATH 2:01 PM | |
| CAUSE OF DEATH HEART DISEASE | | MANNER OF DEATH SUICIDE | | PLACE OF DEATH MEMPHIS, TENNESSEE | |
| MEDICAL HISTORY HYPERTENSION, CORONARY ARTERY DISEASE | | PREVIOUS ILLNESS NONE | | PREVIOUS SURGERY NONE | |
| OCCUPATION MEMBER OF CONGRESS | | EDUCATION COLLEGE GRADUATE | | RELIGION METHODIST | |
| MARITAL STATUS SINGLE | | SOCIAL HISTORY NO ALCOHOL, NO DRUGS | | SIGNATURE OF DECEASED JAMES EARL RAY | |
| SIGNATURE OF PHYSICIAN DR. JAMES H. HAYES | | SIGNATURE OF CORONER DR. JAMES H. HAYES | | SIGNATURE OF WITNESS DR. JAMES H. HAYES | |
| SIGNATURE OF DECEASED JAMES EARL RAY | | SIGNATURE OF DECEASED JAMES EARL RAY | | SIGNATURE OF DECEASED JAMES EARL RAY | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Nannie F. Browne

13559 CERTIFICATE OF DEATH

13549

Reg. Dist. No.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville (Rural)</u> | | | | c. LENGTH OF STAY IN 1b <u>42 y. 7 m. 24 d.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u> | | | | d. STREET ADDRESS <u>21 S. Carey Street</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>F.</u> Last <u>Browne</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. PREVIOUS MARRIAGES <u>WIDOWED</u> | | 8. DATE OF BIRTH <u>September 30, 1865</u> | |
| 9. AGE (In years last birthday) <u>93</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Joseph R. Jeffries</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Miranda Hutt</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u> </u> | | | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT Address <u>Springfield State Hospital Record</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic rheumatic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Mitral stenosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u> </u> years <u> </u> years <u> </u> Years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Manic depressive reaction, depressed type.</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | |
| 20f. (City or town) <u> </u> | | (County) <u> </u> | | (State) <u> </u> | | | |
| 21. I certify that I attended the deceased from <u>November 1, 1955</u> , to <u>December 13, 1958</u> , that I last saw the deceased alive on <u>December 13, 1958</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Elisabeth Knopp</u> | | | | DATE SIGNED <u>12/14/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Elisabeth Knopp, M. D.</u> | | | | <u>Sykesville, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/16/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Fickens & Sons H & Co Aves 17</u> | | | | 24a. REC'D BY REGISTRAR <u>DEC 17 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 8, 9 Film G258 1-28-59 et

13550

CERTIFICATE OF DEATH

13550

Reg. Dist. No.

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster RD #4</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>LAURA MAE BURNE</u> | | | | 4. DATE OF DEATH Month Day Year <u>DEC. 25 1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 21, 1886</u> | |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-wife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Bourne, Mass.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Elmer Ryder</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Laura Delano</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT Address <u>Mr. Russell A. Denbroeder Rd #4 Westminster</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY Insufficiency</u> (c) <u>—</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>12-25</u> , 19 <u>58</u> , to <u>12-25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-25</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>James J. Marsh</u> | | | | ADDRESS (Street, city or town, state) <u>105 E MAIN ST.</u> | | DATE SIGNED <u>12-26-58</u> | |
| PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u> | | | | <u>WESTMINSTER MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Removal</u> | | <u>Dec 26, 58</u> | | <u>Colebrook Cemetery</u> | | <u>Westminster, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr. Westminster, Md.</u> | | | | ADDRESS <u>—</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 30 '58</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Form 10-1 (Rev. 1-1-60)

| | | | |
|-------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|
| <p>1. Name of deceased (Print or type full name) _____</p> | | <p>2. Sex (Print or type) _____</p> | |
| <p>3. Date of birth (Print or type) _____</p> | | <p>4. Place of birth (Print or type) _____</p> | |
| <p>5. Date of death (Print or type) _____</p> | | <p>6. Place of death (Print or type) _____</p> | |
| <p>7. Cause of death (Print or type) _____</p> | | <p>8. Manner of death (Print or type) _____</p> | |
| <p>9. Signature of physician (Print or type) _____</p> | | <p>10. Signature of registrar (Print or type) _____</p> | |
| <p>11. Signature of medical examiner (Print or type) _____</p> | | <p>12. Signature of coroner (Print or type) _____</p> | |
| <p>13. Signature of funeral director (Print or type) _____</p> | | <p>14. Signature of undertaker (Print or type) _____</p> | |
| <p>15. Signature of other (Print or type) _____</p> | | <p>16. Signature of other (Print or type) _____</p> | |
| <p>17. Signature of other (Print or type) _____</p> | | <p>18. Signature of other (Print or type) _____</p> | |
| <p>19. Signature of other (Print or type) _____</p> | | <p>20. Signature of other (Print or type) _____</p> | |
| <p>21. Signature of other (Print or type) _____</p> | | <p>22. Signature of other (Print or type) _____</p> | |
| <p>23. Signature of other (Print or type) _____</p> | | <p>24. Signature of other (Print or type) _____</p> | |
| <p>25. Signature of other (Print or type) _____</p> | | <p>26. Signature of other (Print or type) _____</p> | |
| <p>27. Signature of other (Print or type) _____</p> | | <p>28. Signature of other (Print or type) _____</p> | |
| <p>29. Signature of other (Print or type) _____</p> | | <p>30. Signature of other (Print or type) _____</p> | |
| <p>31. Signature of other (Print or type) _____</p> | | <p>32. Signature of other (Print or type) _____</p> | |
| <p>33. Signature of other (Print or type) _____</p> | | <p>34. Signature of other (Print or type) _____</p> | |
| <p>35. Signature of other (Print or type) _____</p> | | <p>36. Signature of other (Print or type) _____</p> | |
| <p>37. Signature of other (Print or type) _____</p> | | <p>38. Signature of other (Print or type) _____</p> | |
| <p>39. Signature of other (Print or type) _____</p> | | <p>40. Signature of other (Print or type) _____</p> | |
| <p>41. Signature of other (Print or type) _____</p> | | <p>42. Signature of other (Print or type) _____</p> | |
| <p>43. Signature of other (Print or type) _____</p> | | <p>44. Signature of other (Print or type) _____</p> | |
| <p>45. Signature of other (Print or type) _____</p> | | <p>46. Signature of other (Print or type) _____</p> | |
| <p>47. Signature of other (Print or type) _____</p> | | <p>48. Signature of other (Print or type) _____</p> | |
| <p>49. Signature of other (Print or type) _____</p> | | <p>50. Signature of other (Print or type) _____</p> | |
| <p>51. Signature of other (Print or type) _____</p> | | <p>52. Signature of other (Print or type) _____</p> | |
| <p>53. Signature of other (Print or type) _____</p> | | <p>54. Signature of other (Print or type) _____</p> | |
| <p>55. Signature of other (Print or type) _____</p> | | <p>56. Signature of other (Print or type) _____</p> | |
| <p>57. Signature of other (Print or type) _____</p> | | <p>58. Signature of other (Print or type) _____</p> | |
| <p>59. Signature of other (Print or type) _____</p> | | <p>60. Signature of other (Print or type) _____</p> | |
| <p>61. Signature of other (Print or type) _____</p> | | <p>62. Signature of other (Print or type) _____</p> | |
| <p>63. Signature of other (Print or type) _____</p> | | <p>64. Signature of other (Print or type) _____</p> | |
| <p>65. Signature of other (Print or type) _____</p> | | <p>66. Signature of other (Print or type) _____</p> | |
| <p>67. Signature of other (Print or type) _____</p> | | <p>68. Signature of other (Print or type) _____</p> | |
| <p>69. Signature of other (Print or type) _____</p> | | <p>70. Signature of other (Print or type) _____</p> | |
| <p>71. Signature of other (Print or type) _____</p> | | <p>72. Signature of other (Print or type) _____</p> | |
| <p>73. Signature of other (Print or type) _____</p> | | <p>74. Signature of other (Print or type) _____</p> | |
| <p>75. Signature of other (Print or type) _____</p> | | <p>76. Signature of other (Print or type) _____</p> | |
| <p>77. Signature of other (Print or type) _____</p> | | <p>78. Signature of other (Print or type) _____</p> | |
| <p>79. Signature of other (Print or type) _____</p> | | <p>80. Signature of other (Print or type) _____</p> | |
| <p>81. Signature of other (Print or type) _____</p> | | <p>82. Signature of other (Print or type) _____</p> | |
| <p>83. Signature of other (Print or type) _____</p> | | <p>84. Signature of other (Print or type) _____</p> | |
| <p>85. Signature of other (Print or type) _____</p> | | <p>86. Signature of other (Print or type) _____</p> | |
| <p>87. Signature of other (Print or type) _____</p> | | <p>88. Signature of other (Print or type) _____</p> | |
| <p>89. Signature of other (Print or type) _____</p> | | <p>90. Signature of other (Print or type) _____</p> | |
| <p>91. Signature of other (Print or type) _____</p> | | <p>92. Signature of other (Print or type) _____</p> | |
| <p>93. Signature of other (Print or type) _____</p> | | <p>94. Signature of other (Print or type) _____</p> | |
| <p>95. Signature of other (Print or type) _____</p> | | <p>96. Signature of other (Print or type) _____</p> | |
| <p>97. Signature of other (Print or type) _____</p> | | <p>98. Signature of other (Print or type) _____</p> | |
| <p>99. Signature of other (Print or type) _____</p> | | <p>100. Signature of other (Print or type) _____</p> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13561

CERTIFICATE OF DEATH

13551

Reg. Dist. No.

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> | | | | c. LENGTH OF STAY IN 1b <u>10 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>VIRGINIA</u> Last <u>CARR</u> | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>19 58</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1/24/1873</u> | |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | | |
| 13. FATHER'S NAME <u>GRAY</u> | | | | 14. MOTHER'S MAIDEN NAME <u> </u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>217-14-1976</u> | | 17. INFORMANT <u>Record, Springfield State Hosp., Sykes., Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov. 27</u> , 19 <u>58</u> , to <u>Dec. 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 7</u> , 19 <u>58</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Gertrude M. Gross, M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>Springfield State Hospital, Sykesville, Maryland</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Gertrude M. Gross, M. D.</u> | | | | DATE SIGNED <u>12/8/58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u> | | 22b. DATE THEREOF <u>12-1-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u> | | 22d. LOCATION (City, town, or county) (State) <u>Dale Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard Luck</u> | | | | ADDRESS <u>1305 Haywood Rd</u> | | | |
| 24a. REC'D BY REGISTRAR <u> </u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | | DATE <u>DEC 11 58</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|------------------------------------------|--|------------------------------------------|--|------------------------------------------|--|
| <p>1. Name of deceased: _____</p> | | <p>2. Sex: _____</p> | | <p>3. Age: _____</p> | |
| <p>4. Date of death: _____</p> | | <p>5. Time of death: _____</p> | | <p>6. Place of death: _____</p> | |
| <p>7. Cause of death: _____</p> | | <p>8. Immediate cause: _____</p> | | <p>9. Underlying cause: _____</p> | |
| <p>10. Manner of death: _____</p> | | <p>11. Signature of physician: _____</p> | | <p>12. Signature of registrar: _____</p> | |
| <p>13. Signature of informant: _____</p> | | <p>14. Address of informant: _____</p> | | <p>15. City and State: _____</p> | |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13562

Item 1 Film 6257 12-29-58 et
 Item 2 Film 6257 1-2-59 et

CERTIFICATE OF DEATH

13552

Reg. Dist. No.

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | c. LENGTH OF STAY IN 1b <u>5 year</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pullen Nursing Home</u> | | | | d. STREET ADDRESS <u>Second Avenue - Sykesville</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>John R. Marley Cass</u> | | | | 4. DATE OF DEATH <u>December 13 1958</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug. 20 1868</u> | | 9. AGE (In years lost birthday) <u>90</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Priest</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Episcopal Church</u> | | 11. BIRTHPLACE (State or foreign country) <u>England</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Cass</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Marley</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>unk</u> | | 17. INFORMANT <u>Mrs R.R. Hoy - 505 E. 43rd St. Balt. 12, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis, arteriosclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized, Ca of Colon, metastatic Adst.</u> DUE TO (c) <u>Anemia.</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1956 to 12 Dec 58</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1956</u> , 19 <u> </u> , to <u>12 Dec</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10 Dec 1958</u> , and that death occurred at <u>10:50 A</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Sykesville, Md</u> DATE SIGNED <u>12 Dec 58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u> | | | | <u>SYKESVILLE, MD.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-15-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Roman Catholic</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> | | | | ADDRESS <u>Sykesville Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 17 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13563

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 16 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve 22 x 2 | | | |
| | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First Ara Middle Elizabeth Last Chabara | | | | 4. DATE OF DEATH Month 12 Day 14 Year 19 58 | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2-26-76 | |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR Months 9 Days 18 | | IF UNDER 24 HRS. Hours 18 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Sylvester Shockley | | | | 14. MOTHER'S MAIDEN NAME Martha English | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. unkn | | 17. INFORMANT Springf. Hospit. Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis, Moder. advanced active TB | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002X | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-28-, 1958 , to 12-13-, 1958 , that I last saw the deceased alive on 12-13- , 1958 , and that death occurred at 7: A M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edmund Lusthaus M.D. Springfield State Hospital 12-14-58 | | | | | | | |
| ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital 12-14-58 | | | | | | | |
| PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. Sykesville, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 12/17/58 | | Bivalve Cem. | | Bivalve, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. H. Messitt, Bivalve, Md. | | | | 24a. REC'D BY REGISTRAR DATE DEC 19 58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraws | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13564

CERTIFICATE OF DEATH

13554

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Unknown | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 14yrs. 9mth 16days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital. | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13 | | | |
| d. STREET ADDRESS 3703 Belair Rd. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First George Middle Henry Last Chaney | | | | 4. DATE OF DEATH Month 12 Day 19 Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-18- 92 | |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boxer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME George W. Chaney | | | | 14. MOTHER'S MAIDEN NAME Anastatia Cummings | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Hospital records. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden death by asphyxia 921.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) a piece of meat in the throat DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type. INTERVAL BETWEEN ONSET AND DEATH seconds | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster Md DATE SIGNED 12/20/58 ACTUAL SIGNATURE Ullrich M.D. Westminster Md PHYSICIAN'S NAME (Type) Ullrich | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/24/58 | | 22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 22d. LOCATION (City, town, or county) (State) Parkville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road. | | | | 24a. REC'D BY REGISTRAR DATE DEC 29 1958 | | 24b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13565 CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown | | | | c. LENGTH OF STAY IN 1b 1 1/2 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS Broad Street | | | |
| 3. NAME OF DECEASED (Type or print) First Roy Middle Collins Last | | | | 4. DATE OF DEATH Month December Day 21 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 1, 1917 | | 9. AGE (In years lost birthday) 41 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Rubber Factory | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Abram Collins | | | | 14. MOTHER'S MAIDEN NAME Ruthie Gibson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 230-24-7611 | | 17. INFORMANT Mrs. Grace Collins, Taneytown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Angiotrophic, Progressive Spinal DUE TO (c) 10 mos? | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/14 , 19 58 , to 12/21 , 19 58 , that I last saw the deceased alive on 12/21 , 19 58 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE R. S. McVaugh | | | | ADDRESS (Street, city or town, state) 49 Frederick St. Taneytown Md. | | | |
| PHYSICIAN'S NAME (Type) R. S. McVaugh | | | | DATE SIGNED 12/22/58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/26/58 | | 22c. NAME OF CEMETERY OR CREMATORY Pleasant Point Cemetery | | 22d. LOCATION (City, town, or county) (State) Tazewell, Tennessee | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss C.O. Fuss & Son, Taneytown, Maryland | | | | 24a. RECEIVED BY REGISTRAR DEC 24 58 DATE | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1965 CERTIFICATE OF DEATH

County of

City of

State of

Decedent

Decedent's

Age

Sex

Married

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13566

CERTIFICATE OF DEATH

Reg. Dist. No.

13556

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| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u> | | | | c. LENGTH OF STAY IN 1b <u>712 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u> | | | | d. STREET ADDRESS <u>611 Pitcher Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Marjorie</u> Middle <u>Jean</u> Last <u>Coward</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>19 58</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-15-34</u> | |
| 9. AGE (In years last birthday) <u>23</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | | | | | |
| 13. FATHER'S NAME <u>Vernon Peacock</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Virginia Smith</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Virginia Drumgoe</u> Address <u>611 Pitcher Street</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advance bilateral cavitory pulmonary tbc.</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>January 24</u> , 19 <u>56</u> , to <u>December 13</u> , 19 <u>58</u> that I last saw the deceased alive on <u>December 13</u> , 19 <u>58</u> , and that death occurred at <u>2:15 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Henryton, Maryland</u> DATE SIGNED <u>12-13-58</u> ACTUAL SIGNATURE <u>B. M. Mosley M. D.</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. Edgars M. Maculans, Supt.</u> <u>Henryton State Hospital, Henryton, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Dec. 16, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Russ</u> | | | | 24. REC'D BY REGISTRAR <u>2222 W. North</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> | |

CERTIFICATE OF DEATH

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|----------------------------|--|----------------------------|--|--------------------------|--|-----------------------------------------|--|-------------------------------------|--|-----------------------------------|--|--------------------------------------|--|----------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. OCCUPATION | | 7. MARITAL STATUS | | 8. COLOR | |
| JAMES EARL RAY | | M | | 39 | | 12-1-27 | | MOBILE, ALABAMA | | LABORER | | SINGLE | | WHITE | |
| 9. DATE OF DEATH | | 10. TIME OF DEATH | | 11. PLACE OF DEATH | | 12. CAUSE OF DEATH | | 13. MANNER OF DEATH | | 14. SIGNATURE OF PHYSICIAN | | 15. SIGNATURE OF REGISTRAR | | 16. SIGNATURE OF WITNESS | |
| 4-4-68 | | 10:30 AM | | BALTIMORE, MARYLAND | | HEART DISEASE | | NATURAL | | [Signature] | | [Signature] | | [Signature] | |
| 17. FULL NAME OF PHYSICIAN | | 18. FULL NAME OF REGISTRAR | | 19. FULL NAME OF WITNESS | | 20. FULL NAME OF DECEASED'S NEXT OF KIN | | 21. FULL NAME OF DECEASED'S ADDRESS | | 22. FULL NAME OF DECEASED'S PHONE | | 23. FULL NAME OF DECEASED'S RELIGION | | 24. FULL NAME OF DECEASED'S RACE | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13567

CERTIFICATE OF DEATH

13557

Reg. Dist. No.

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN IB 1 mon. 8 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | 1 d. STREET ADDRESS 209 Penrose Street | |
| 3. NAME OF DECEASED (Type or print) First EDITH Middle SPAHR Last CRAMER | | 4. DATE OF DEATH Month December Day 2 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-16-84 |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR Months 7 Days 14 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John William Cramer | | 14. MOTHER'S MAIDEN NAME Rebecca Elizabeth Spahr | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. ---- | |
| 17. INFORMANT Records, Springfield State Hospital | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychotic depressive reaction | | INTERVAL BETWEEN ONSET AND DEATH Years | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 24, 1958 , to December 2, 1958 , that I last saw the deceased alive on December 2, 1958 , and that death occurred at 7:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M. D. Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 12/5/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY MT HOPE | | 22d. LOCATION (City, town, or county) (State) WOODSBORO MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Buell & Hartzler, Woodboro, Md | | 24a. REC'D BY REGISTRAR DATE DEC 4 '58 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

CERTIFICATE OF DEATH

| | | | | | |
|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. RACE | | 5. BIRTH DATE | | 6. BIRTH PLACE | |
| 7. MARRIAGE DATE | | 8. OCCUPATION | | 9. CAUSE OF DEATH | |
| 10. PLACE OF DEATH | | 11. TIME OF DEATH | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESS | | 15. SIGNATURE OF DECEASED | |
| 16. SIGNATURE OF DECEASED | | 17. SIGNATURE OF DECEASED | | 18. SIGNATURE OF DECEASED | |
| 19. SIGNATURE OF DECEASED | | 20. SIGNATURE OF DECEASED | | 21. SIGNATURE OF DECEASED | |
| 22. SIGNATURE OF DECEASED | | 23. SIGNATURE OF DECEASED | | 24. SIGNATURE OF DECEASED | |
| 25. SIGNATURE OF DECEASED | | 26. SIGNATURE OF DECEASED | | 27. SIGNATURE OF DECEASED | |
| 28. SIGNATURE OF DECEASED | | 29. SIGNATURE OF DECEASED | | 30. SIGNATURE OF DECEASED | |
| 31. SIGNATURE OF DECEASED | | 32. SIGNATURE OF DECEASED | | 33. SIGNATURE OF DECEASED | |
| 34. SIGNATURE OF DECEASED | | 35. SIGNATURE OF DECEASED | | 36. SIGNATURE OF DECEASED | |
| 37. SIGNATURE OF DECEASED | | 38. SIGNATURE OF DECEASED | | 39. SIGNATURE OF DECEASED | |
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| 43. SIGNATURE OF DECEASED | | 44. SIGNATURE OF DECEASED | | 45. SIGNATURE OF DECEASED | |
| 46. SIGNATURE OF DECEASED | | 47. SIGNATURE OF DECEASED | | 48. SIGNATURE OF DECEASED | |
| 49. SIGNATURE OF DECEASED | | 50. SIGNATURE OF DECEASED | | 51. SIGNATURE OF DECEASED | |
| 52. SIGNATURE OF DECEASED | | 53. SIGNATURE OF DECEASED | | 54. SIGNATURE OF DECEASED | |
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| 58. SIGNATURE OF DECEASED | | 59. SIGNATURE OF DECEASED | | 60. SIGNATURE OF DECEASED | |
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| 64. SIGNATURE OF DECEASED | | 65. SIGNATURE OF DECEASED | | 66. SIGNATURE OF DECEASED | |
| 67. SIGNATURE OF DECEASED | | 68. SIGNATURE OF DECEASED | | 69. SIGNATURE OF DECEASED | |
| 70. SIGNATURE OF DECEASED | | 71. SIGNATURE OF DECEASED | | 72. SIGNATURE OF DECEASED | |
| 73. SIGNATURE OF DECEASED | | 74. SIGNATURE OF DECEASED | | 75. SIGNATURE OF DECEASED | |
| 76. SIGNATURE OF DECEASED | | 77. SIGNATURE OF DECEASED | | 78. SIGNATURE OF DECEASED | |
| 79. SIGNATURE OF DECEASED | | 80. SIGNATURE OF DECEASED | | 81. SIGNATURE OF DECEASED | |
| 82. SIGNATURE OF DECEASED | | 83. SIGNATURE OF DECEASED | | 84. SIGNATURE OF DECEASED | |
| 85. SIGNATURE OF DECEASED | | 86. SIGNATURE OF DECEASED | | 87. SIGNATURE OF DECEASED | |
| 88. SIGNATURE OF DECEASED | | 89. SIGNATURE OF DECEASED | | 90. SIGNATURE OF DECEASED | |
| 91. SIGNATURE OF DECEASED | | 92. SIGNATURE OF DECEASED | | 93. SIGNATURE OF DECEASED | |
| 94. SIGNATURE OF DECEASED | | 95. SIGNATURE OF DECEASED | | 96. SIGNATURE OF DECEASED | |
| 97. SIGNATURE OF DECEASED | | 98. SIGNATURE OF DECEASED | | 99. SIGNATURE OF DECEASED | |
| 100. SIGNATURE OF DECEASED | | 101. SIGNATURE OF DECEASED | | 102. SIGNATURE OF DECEASED | |

103. SIGNATURE OF DECEASED

13550 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll Co</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>45 Church St</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY CORINNE CRAWMER</u> | | 4. DATE OF DEATH Month Day Year <u>Dec 7 1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 4, 1890</u> |
| 9. AGE (In years lost birthday) <u>68</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Ornate clothing</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Miford Carroll Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Walter B. Dunsall</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Gilbert</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>212-245250</u> | |
| 17. INFORMANT <u>Phillip B. Crawmer, Westminster Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>vascular disease</u> DUE TO <u>same</u> (c) <u>none</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>about 1 year</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 1st</u> , 19 <u>58</u> , to <u>Dec 7th</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 6th</u> , 19 <u>58</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>C. L. Billingslea</u> | | ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u> | | DATE SIGNED <u>12-8-58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Dec 10, 58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Meyer, Jr. Westminster, Md.</u> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <u>DEC 10 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13568

CERTIFICATE OF DEATH

13559

Reg. Dist. No.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 43y. 5m. 15d. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS ----- | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last CROOKS | | | | 4. DATE OF DEATH Month December Day 15 Year 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-10-84 | |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mattress maker | | | | 10b. KIND OF BUSINESS OR INDUSTRY unk | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William H. Crooks | | | | 14. MOTHER'S MAIDEN NAME Hannah Mary Fogle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. unk. | | 17. INFORMANT Address Records, Springfield State Hospital | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Years Years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Springfield State Hospital | | | | 20g. (County) Carroll | | 20h. (State) Md. | |
| 21. I certify that I attended the deceased from March 7 , 19 55 , to December 15 , 19 58 , that I last saw the deceased alive on December 15 , 19 58 , and that death occurred at 10:40 A .M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12-15-58 | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo | | | | M.D. Springfield State Hospital | | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M. D. | | | | Sykesville, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-17-58 | | 22c. NAME OF CEMETERY OR CREMATORY Freedom | | 22d. LOCATION (City, town, or county) (State) Edwards, Carroll Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Hight | | | | ADDRESS Sykesville, Md. | | 24a. REC'D BY REGISTRAR DATE DEC 19 '58 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Frank | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 ISM 9/55

Approved by Dr. James Marsh, Deputy Med. Examiner

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13569 CERTIFICATE OF DEATH

13560

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 23yrs. 8mos. 11days Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS Formerly—Queen Anne Rd. 13800 W. Woodspring Lane | | | |
| 3. NAME OF DECEASED (Type or print) First Andrew Middle Alexander Last Danko | | | | 4. DATE OF DEATH Month December Day 31 , Year 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 11, 1906 | 9. AGE (In years last birthday) 52 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pattern Maker | | 10b. KIND OF BUSINESS OR INDUSTRY Wood and Metal | | 11. BIRTHPLACE (State or foreign country) Mahwah, New Jersey | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME J. Michael Danko | | | | 14. MOTHER'S MAIDEN NAME Julia Dudics | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction due to arteriosclerotic coronary thrombosis. DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy without psychosis. Fracture, neck of femur, right. | | | | | | INTERVAL BETWEEN ONSET AND DEATH Minutes | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 20, 1954 to December 31, 1958 that I last saw the deceased alive on December 31, 1958 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Edmund Lusthaus M.D. | | | | ADDRESS (Street, city or town, state) Springfield State Hospital | | DATE SIGNED 12/31/58 | |
| PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/3/59 | | 22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons—Baltimore, Md. | | | | 24a. REC'D BY REGISTRAR DATE 5 1959 | | 24b. REGISTRAR'S SIGNATURE Wm. S. Hanna | |

13003 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

See Back

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|---------------|--|----------------|--|----------------|--|-----------------|--|---------------------|--|---------------------|--|
| DATE OF BIRTH | | PLACE OF BIRTH | | MARRIAGE | | EDUCATION | | OCCUPATION | | MILITARY SERVICE | |
| JAN 1 1900 | | BALTIMORE, MD | | MARRIED | | HIGH SCHOOL | | LABORER | | NONE | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DURATION OF ILLNESS | | PREVIOUS ILLNESS | |
| JAN 1 1900 | | BALTIMORE, MD | | HEART DISEASE | | NATURAL | | ONE YEAR | | NONE | |
| AGE | | SEX | | RACE | | RELIGION | | BLOOD GROUP | | TUBERCULIN REACTION | |
| 30 | | M | | W | | C | | O | | POSITIVE | |
| DATE OF BIRTH | | PLACE OF BIRTH | | MARRIAGE | | EDUCATION | | OCCUPATION | | MILITARY SERVICE | |
| JAN 1 1900 | | BALTIMORE, MD | | MARRIED | | HIGH SCHOOL | | LABORER | | NONE | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DURATION OF ILLNESS | | PREVIOUS ILLNESS | |
| JAN 1 1900 | | BALTIMORE, MD | | HEART DISEASE | | NATURAL | | ONE YEAR | | NONE | |
| AGE | | SEX | | RACE | | RELIGION | | BLOOD GROUP | | TUBERCULIN REACTION | |
| 30 | | M | | W | | C | | O | | POSITIVE | |

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13570

CERTIFICATE OF DEATH

13561

Reg. Dist. No.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton | | | | c. LENGTH OF STAY IN 1b 726 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | | | d. STREET ADDRESS Route 1, Box 9 | | | |
| 3. NAME OF DECEASED (Type or print) First Gertrude Middle Jeanette Last Dashields | | | | 4. DATE OF DEATH Month December Day 31 Year 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 1, 1918 | |
| 9. AGE (In years last birthday) 40 | | IF UNDER 1 YEAR Months 14 Days 2 | | IF UNDER 24 HRS. Hours 14 Min. 2 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Rock Hall, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Joshua Gaines | | | | 14. MOTHER'S MAIDEN NAME Rosie Butler | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Gertrude J. Dashields - Patient | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Far Advanced Bilateral Pulmonary Tuberculosis DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from January 4, 1957 , to December 31, 1958 , that I last saw the deceased alive on December 31, 1958 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE E. M. Maculans | | | | ADDRESS (Street, city or town, state) Henryton, Maryland | | | |
| DATE SIGNED 12-31-58 | | | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Edgar M. Maculans, Supt. Henryton State Hospital, Henryton, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/2/59 | | 22c. NAME OF CEMETERY OR CREMATORY Sharptown Cemetery | | 22d. LOCATION (City, town, or county) (State) Rock Hall, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams - Chesapeake, Ind | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE JAN 5 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. House | | | | | | | |

1950

CERTIFICATE OF DEATH

1950

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

| | | | |
|-----------------------|--|------------------------|--|
| DATE OF DEATH | | PLACE OF DEATH | |
| JAN 10 1950 | | BALTIMORE, MARYLAND | |
| DECEASED | | SEX | |
| JAMES EARL RAY | | MALE | |
| AGE | | RACE | |
| 35 | | WHITE | |
| BIRTH DATE | | BIRTH PLACE | |
| JAN 10 1915 | | BALTIMORE, MARYLAND | |
| MARRIAGE | | OCCUPATION | |
| MARRIED | | LABORER | |
| EDUCATION | | RELIGION | |
| HIGH SCHOOL | | METHODIST | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| HEART DISEASE | | NATURAL | |
| DETAILS OF DEATH | | SIGNATURE OF PHYSICIAN | |
| DECEASED WAS FOUND BY | | DATE OF EXAMINATION | |
| FAMILY | | JAN 10 1950 | |
| PLACE OF BURIAL | | SIGNATURE OF REGISTRAR | |
| BALTIMORE CEMETERY | | JAN 10 1950 | |
| DATE OF BURIAL | | SIGNATURE OF CLERK | |
| JAN 10 1950 | | JAN 10 1950 | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR THE PURPOSES OF THE FEDERAL BUREAU OF INVESTIGATION.

1950

13571 CERTIFICATE OF DEATH

13562

Reg. Dist. No.

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 24 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12, Md. | | | |
| f. STREET ADDRESS 5503 Hillen Road | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle Adam Last Dressel | | | | 4. DATE OF DEATH Month 12 Day 28 Year 1958 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-29-94 | |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR Months 64 Days 28 Hours 19 Min. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shipping clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME John G. Dressel | | | | 14. MOTHER'S MAIDEN NAME Katherine Lenhoff | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. 218-03-9129 | | 17. INFORMANT S.S. Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) C.B.S. assoc. with cerebral arterioscler. with psych. reaction Convulsive seizures | | | | INTERVAL BETWEEN ONSET AND DEATH years years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) Springfield State Hospital | | | | 20g. (County) City | | | |
| 20h. (State) Md. | | | | 21. I certify that I attended the deceased from 12-4- 1958 , to 12-28- 1958 , that I last saw the deceased alive on 12-28- 1958 , and that death occurred at 11:10A M, from the causes and on the date stated above. | | | |
| 22. BURIAL, CREMATION, REMOVAL (Specify) 12-31-58 | | | | 22b. DATE THEREOF 12-31-58 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Morland Park | | | | 22d. LOCATION (City, town, or county) Bald Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edmund B. Lusthaus | | | | 24. REC'D BY REGISTRAR DATE DEC 30 '58 | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hanks | | | | 24c. REGISTRAR'S SIGNATURE Arthur S. Hanks | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13563

Reg. Dist. No. _____

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13573 CERTIFICATE OF DEATH

Reg. Dist. No. 13564

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>Main St.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>CLARA Belle DUDDER</u> | | 4. DATE OF DEATH <u>December 15 1958</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 12, 1876</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>George Beasman</u> | | 14. MOTHER'S MAIDEN NAME <u>Marion S. Worsey</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>219-14-9626</u> | |
| 17. INFORMANT <u>Mrs. LeRoy Keeney - Sykesville, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X SENILE ARTERIOSCLEROTIC NEPHROSCLEROSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u> <u>15 yrs.</u> <u>20 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1935</u> , 19 <u> </u> , to <u>15 December, 1958</u> , that I last saw the deceased alive on <u>15 December</u> , 19 <u>58</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>12/15/58</u> | | | |
| ACTUAL SIGNATURE <u>W. H. Lawson, Jr.</u> M.D. | | DATE SIGNED <u>12/15/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u> | | Address <u>Sykesville P.O., Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-18-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u> | | 22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Sykesville, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DEC 22 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13574 CERTIFICATE OF DEATH

13565

Reg. Dist. No.

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | | | c. LENGTH OF STAY IN 1b <u>12y.6m.3d.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u> | | | | d. STREET ADDRESS <u>3V01-4</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>BEATRICE</u> Last <u>DUNBAR</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6-11-89</u> | |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Goods Store</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>John Clark Cawood</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Harriet Holmes</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>unk</u> | | 17. INFORMANT <u>Records, Springfield State Hospital</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombophlebitis, left leg</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic reaction, paranoid type</u> INTERVAL BETWEEN ONSET AND DEATH Hours <u> </u> Days <u> </u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | | | | | | | |
| 21. I certify that I attended the deceased from <u>March 7, 1955</u> to <u>December 11, 1958</u> , that I last saw the deceased alive on <u>December 11, 1958</u> , and that death occurred at <u>7:15 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>12-12-58</u> ACTUAL SIGNATURE <u>Agustin del Campo</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>Agustin del Campo</u> <u>Sykesville, Maryland</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-17-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hargrett</u> | | | | ADDRESS <u>Sykesville, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 19 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hargrett</u> | | | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13575

CERTIFICATE OF DEATH

13566

Reg. Dist. No.

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 9mos. 2 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS None | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle William Last Duvall, Sr. | | | | 4. DATE OF DEATH Month December Day 30 , Year 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> Never | | 8. DATE OF BIRTH July 24, 1884 | |
| 9. AGE (In years last birthday) yrs. 74 | | IF UNDER 1 YEAR Months 74 | | IF UNDER 24 HRS. Days 74 Hours 74 Min. 74 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY FARM - | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Edward Duvall | | | | 14. MOTHER'S MAIDEN NAME Katherine Lent | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Springfield Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombophlebitis, right leg DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. (c) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH Months Years | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from March 28, 1958 to December 30, 1958 , that I last saw the deceased alive on December 29, 1958 , and that death occurred at 7:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 12/30/58 | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo M.D. | | | | PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 1/1/59 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Sanage Cemetery | | | | 22d. LOCATION (City, town, or county) (State) Sanage Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert W. Harwood, Samuel, Md | | | | 24. REC'D BY REGISTRAR DATE JAN 5 '59 | | | |
| 25. REGISTRAR'S SIGNATURE Carlton S. House | | | | | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------------|--|------------------------|--|---------------------------------|--|----------------------|--|-----------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | |
| John William | | Male | | 45 | | Jan 15, 1880 | | Boston, Mass. | |
| Cause of Death | | Disease | | Symptoms | | Duration | | Time of Day | |
| Heart Disease | | Myocardial Infarction | | Chest Pain, Shortness of Breath | | 2 Weeks | | 10:30 AM | |
| Place of Death | | Occupation | | Education | | Marital Status | | Religion | |
| Home | | Carpenter | | High School | | Married | | Roman Catholic | |
| Signature of Physician | | Signature of Registrar | | Signature of Informant | | Signature of Witness | | Signature of Coroner | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| Date of Death | | Time of Death | | Place of Death | | Cause of Death | | Disease | |
| Jan 20, 1925 | | 10:30 AM | | Home | | Heart Disease | | Myocardial Infarction | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13576 CERTIFICATE OF DEATH

13567

Reg. Dist. No.

| | | | |
|------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 2yrs. 7mos. 28days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 2103.2 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | d. STREET ADDRESS 329 S. Mulberry St. | |
| 3. NAME OF DECEASED (Type or print) First Freda Middle Dorthea Last Gohn Free | | 4. DATE OF DEATH Month Dece Day mber Year 29 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 5, 1880 |
| 9. AGE (In years last birthday) 78 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Lawrence Spencer Gohn | | 14. MOTHER'S MAIDEN NAME Caroline Rosenthal | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address | |

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) C.B.S. assoc. with senile brain disease with psychotic reaction. | | INTERVAL BETWEEN ONSET AND DEATH Days Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 1, 1956 , to December 29, 1958 , that I last saw the deceased alive on December 29, 1958 , and that death occurred at 9:44 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12/29/58 | | | |
| ACTUAL SIGNATURE Edmund Lusthaus | | M.D. Springfield State Hospital | |
| PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| BURIAL | 12/31/58 | Rest Haven Cemetery | Hagerstown Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel | | 24a. REC'D BY REGISTRAR George H. Hoffberger | |
| ADDRESS Hagerstown Md | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thoms | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

10. MEDICAL CERTIFICATION

VS. AISME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13577 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13568

Reg. Dist. No.

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown R. #2 c. LENGTH OF STAY IN 1b Westminster R#3 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster R#3 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Vera Hope Gamber | | 4. DATE OF DEATH Month Dec. Day 3, Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 2, 1925 |
| 9. AGE (In years, last birthday) 33 yrs. | | 10. IF UNDER 1 YEAR Months 3 Days 19 Hours 58 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John C. Powell | | 14. MOTHER'S MAIDEN NAME Bessie Unglesbee | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 217-20-7341 | |
| 17. INFORMANT Frank Gamber, Westminster, R#3, Md | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suicide by drowning 975X DUE TO Conditions, if any, which gave rise to immediate cause (b) Depressive phycosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH 3 months | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) suicide by drowning | |
| 20c. TIME OF INJURY Month, Day, Year 10:00 A.M. 12/3/58 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Monocacy River | | 20f. (City or town) Taneytown, Carroll, Maryl. (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE R. S. McVagh | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) R. S. McVagh, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/6/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery | | 22d. LOCATION (City, town, or county) Mt. Airy, Carroll, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons | | ADDRESS Reisterstown, Md. | |
| 24a. REC'D BY REGISTRAR DADEC 8 '58 | | 24b. REGISTRAR'S SIGNATURE Carlton E. Kraus | |

| | | | |
|---------------------------------------------------------------------|--|-------------------------------------------------------|--|
| <p>1. Name of deceased: John C. Powell</p> | | <p>2. Date of death: Dec. 1, 1925</p> | |
| <p>3. Place of death: Frank Chamber, Westminster, Md.</p> | | <p>4. Cause of death: Outside by drowning</p> | |
| <p>5. Sex: Male</p> | | <p>6. Race: White</p> | |
| <p>7. Age: 35</p> | | <p>8. Occupation: Boatman</p> | |
| <p>9. Marital status: Married</p> | | <p>10. Residence: Westminster, Md.</p> | |
| <p>11. Burial place: St. John's Cemetery, Baltimore, Md.</p> | | <p>12. Date of burial: Dec. 3, 1925</p> | |
| <p>13. Name of informant: John C. Powell</p> | | <p>14. Signature of informant: <i>[Signature]</i></p> | |
| <p>15. Name of physician: Dr. J. H. Smith</p> | | <p>16. Signature of physician: <i>[Signature]</i></p> | |
| <p>17. Name of coroner: John C. Powell</p> | | <p>18. Signature of coroner: <i>[Signature]</i></p> | |
| <p>19. Name of registrar: John C. Powell</p> | | <p>20. Signature of registrar: <i>[Signature]</i></p> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13578 CERTIFICATE OF DEATH

Reg. Dist. No.

13569

| | | | | | | | |
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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton | | | | c. LENGTH OF STAY IN 1b 186 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 22x-2 | | | |
| 3. NAME OF DECEASED (Type or print) First Frank Middle Garrison Last Garrison | | | | 4. DATE OF DEATH Month December Day 20 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-12-1899 | 9. AGE (In years last birthday) 59 yrs. | IF UNDER 1 YEAR Months 59 | IF UNDER 24 HRS. Days 59 Hours 59 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY CHICKEN FACTORY | | 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Frank Garrison, Sr. | | | | 14. MOTHER'S MAIDEN NAME Sally Linden | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes | | 16. SOCIAL SECURITY NO. 185-05-2433 | | 17. INFORMANT Frank Garrison - Patient | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Moderately advanced pulmonary tuberculosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour 19 Month, Day, Year a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Henryton, Maryland | | (County) | (State) | |
| 21. I certify that I attended the deceased from June 17 , 19 58 , to December 20 19 58 , that I last saw the deceased alive on December 20 , 19 58 , and that death occurred at 1:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 12-20-58 ACTUAL SIGNATURE E. M. Maculans M.D. PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 12-24-58 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery | 22d. LOCATION (City, town, or county) Fruitland | (State) Ind | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. J. Stewart - Funeral Home, Salisbury, Md. | | | 24a. REC'D BY REGISTRAR DEC 29 '58 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kneass | | | |

CERTIFICATE OF DEATH

13302

13354

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|--------------------------------------|--|-------------------------------------|--|-----------------------------------------|--|
| NAME OF DECEASED [Illegible] | | SEX [Illegible] | | AGE [Illegible] | |
| DATE OF BIRTH [Illegible] | | PLACE OF BIRTH [Illegible] | | RACE [Illegible] | |
| DATE OF DEATH [Illegible] | | PLACE OF DEATH [Illegible] | | TIME OF DEATH [Illegible] | |
| CAUSE OF DEATH [Illegible] | | MANNER OF DEATH [Illegible] | | MEDICAL ATTENDANT [Illegible] | |
| INTERVIEWED BY [Illegible] | | DATE OF INTERVIEW [Illegible] | | SIGNATURE OF INTERVIEWER [Illegible] | |
| SIGNATURE OF DECEASED [Illegible] | | SIGNATURE OF WITNESS [Illegible] | | SIGNATURE OF PHYSICIAN [Illegible] | |
| SIGNATURE OF CORONER [Illegible] | | SIGNATURE OF JURY [Illegible] | | SIGNATURE OF JUDGE [Illegible] | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13579

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13570

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville (rural)</u> | | c. LENGTH OF STAY IN 1b <u>19y. 4m. 14d.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u> | | d. STREET ADDRESS <u>3439 Everhart Street</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u></u> Last <u>HARRIS</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Unknown</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | 10. IF UNDER 1 YEAR Months <u></u> Days <u></u> | 11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>Springfield State Hospital Record</u> | | Address <u></u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Involuntional psychotic reaction</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. <u></u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>James T. Marsh</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>James T. Marsh, M. D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/> | | 22b. DATE THEREOF <u>12-19-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Rickards, Inc.</u> | | 24a. REC'D BY REGISTRAR <u>Arthur S. Evans</u> | |
| 24b. REGISTRAR'S SIGNATURE | | DATE <u>DEC 24 '58</u> | |

MEDICAL CERTIFICATION

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15

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12-15-58

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13580 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13571

Reg. Dist. No.

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy | c. LENGTH OF STAY IN 1b 37 yrs. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mt. Airy | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS N. Main | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First PAULINE Middle BELLE Last HARRISON | | 4. DATE OF DEATH Month DEC Day 12 Year 1958 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-9-1892 |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Edward Crumrine | | 14. MOTHER'S MAIDEN NAME Martha Virginia Alexander | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no | | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Address B. C. Harrison, Same |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STRANGULATION 974X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hanging (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH immediate | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) HANGING | |
| 20c. TIME OF INJURY Month, Day, Year 10 Hour o. m. 12-12-1958 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | 20f. (City or town) (County) (State) Mt Airy Carroll Md |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE James J. Marsh | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type or print) JAMES T. MARSH | | DATE SIGNED 12-12-58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 12-15-1958 | 22c. NAME OF CEMETERY OR CREMATORY Pine Grove | 22d. LOCATION (City, town, or county) (State) Mt. Airy, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, | | ADDRESS Winfield, Maryland | |
| 24a. REC'D BY REGISTRAR DATE DEC 15 '58 | | 24b. REGISTRAR'S SIGNATURE C. M. Waltz | |

1. Name of deceased
2. Sex
3. Age
4. Date of death
5. Place of death
6. Cause of death
7. Manner of death
8. Signature of attending physician
9. Signature of medical examiner
10. Signature of coroner
11. Signature of jury
12. Signature of registrar

MARY AND STATE DEPARTMENT OF HEALTH - BATHING IS
1924 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of death: [illegible]
5. Place of death: [illegible]
6. Cause of death: [illegible]
7. Manner of death: [illegible]
8. Signature of attending physician: [illegible]
9. Signature of medical examiner: [illegible]
10. Signature of coroner: [illegible]
11. Signature of jury: [illegible]
12. Signature of registrar: [illegible]

1924

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13581

CERTIFICATE OF DEATH

Reg. Dist. No. 13572

| | | | | | | | |
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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 15y., 25d. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle GEORGE Last HIDDEN | | | | 4. DATE OF DEATH Month December Day 17 Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 1-26-84 | |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Richard R. Hidden | | | | 14. MOTHER'S MAIDEN NAME Katherine Agena | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Records, Springfield State Hospital | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH Days Days Years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic depressive reaction, manic type | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from March 7, 1955 , to December 17, 1958 , that I last saw the deceased alive on December 17, 1958 , and that death occurred at 3:15 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Agustin del Campo</i> | | | | ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 12-17-58 | | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M. D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF Dec. 21, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 22d. LOCATION (City, town, or county) (State) St. Mary's City, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc. | | | | ADDRESS Baltimore, Md. | | 24a. REC'D BY REGISTRAR DATE DEC 23 '58 | |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Piers</i> | | | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13582

CERTIFICATE OF DEATH

13573

Reg. Dist. No.

| | | | | | | | |
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| 1. PLACE OF DEATH a. COUNTY Sykesville MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN lb 59y.7m.24d. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS ----- | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Irwin Middle Hirsh Last Hirsh | | | | 4. DATE OF DEATH Month December Day 7 Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1879 | |
| 9. AGE (In years last birthday) yrs. 79 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Hirsh | | | | 14. MOTHER'S MAIDEN NAME Lina Banberger | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. unk | | 17. INFORMANT Records, Springfield State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 609X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute renal failure DUE TO (c) Urinary tract infection | | INTERVAL BETWEEN ONSET AND DEATH Days Days Days | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental deficiency | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 7 , 19 55 , to December 7 19 58 , that I last saw the deceased alive on December 7 , 19 58 , and that death occurred on 11:10 P M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo M.D. | | | | ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12-7-58 | | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-9-58 | | 22c. NAME OF CEMETERY OR CREMATORY East View | | 22d. LOCATION (City, town, or county) (State) Cumberland Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George | | | | ADDRESS Cumberland, Md. | | 24a. REC'D BY REGISTRAR DEC 10 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Charles L. George | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13522

1914

| | | | |
|-------------------------------------------------------|--|----------------------------------------------------------|--|
| <p>1. Name of deceased: <i>John Doe</i></p> | | <p>2. Sex: <i>Male</i></p> | |
| <p>3. Age: <i>45</i></p> | | <p>4. Date of birth: <i>Jan 15, 1869</i></p> | |
| <p>5. Place of birth: <i>Massachusetts</i></p> | | <p>6. Date of death: <i>Dec 10, 1914</i></p> | |
| <p>7. Cause of death: <i>Heart disease</i></p> | | <p>8. Place of death: <i>Home</i></p> | |
| <p>9. Signature of physician: <i>Dr. J. Smith</i></p> | | <p>10. Signature of registrar: <i>John Doe</i></p> | |
| <p>11. Date of registration: <i>Dec 15, 1914</i></p> | | <p>12. Office of registration: <i>City of Boston</i></p> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13583

CERTIFICATE OF DEATH

Reg. Dist. No.

13574

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | | | c. LENGTH OF STAY IN 1b <u>2yrs.2mos.3dys</u> <u>X</u> <u>Westminster</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Ermina</u> Last <u>Hughes</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>19 58</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12/5/77</u> | |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>William H. Grumbine</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret E. SWOPE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u> | | | | 17. INFORMANT <u>Springfield Hospital Records</u> Address <u>-</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease.</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with circulatory disturbance, with psychotic reaction.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>9/28</u> , 19 <u>56</u> , to <u>12/1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/1</u> , 19 <u>58</u> , and that death occurred at <u>10:00a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>12/1/58</u> ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D. <u>Springfield State Hospital</u> PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus, M.D.</u> <u>Sykesville, Maryland</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/4/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Westminster Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u> ADDRESS <u>Westminster Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>DEC 4 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13584

CERTIFICATE OF DEATH

13575

Reg. Dist. No.

| | | | | | | | |
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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 21yrs. 5mos. 11days Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS S. Augusta Avenue | | | |
| 3. NAME OF DECEASED (Type or print) First Nettie Middle Regina Last Johanning | | | | 4. DATE OF DEATH Month December Day 21 Year 1958 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 17, 1879 | | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Johanning, Jr. | | | | 14. MOTHER'S MAIDEN NAME Catherine T. Gilchrist | | | |
| 15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. unk | | 17. INFORMANT Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis due to convulsive disorder, epileptic deterioration. Bronchopneumonia. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Years Years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from October 20, 1954 to December 21, 1958 , that I last saw the deceased alive on December 21, 1958 , and that death occurred at 8:46P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12/22/58 | | | | | | | |
| ACTUAL SIGNATURE Edmund Lusthaus M.D. | | | | PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-23-58 | | 22c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight - Sykesville, Md. | | | | 24a. REC'D BY REGISTRAR DEC 29 1958 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|-------------------------------|--|------------------------|--|-----------------------|--|---------------------------|--|------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES M. SMITH | | Male | | 45 | | Jan 15, 1900 | | Baltimore, Md. | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | |
| 1234 Main St., Baltimore, Md. | | Carpenter | | Heart Disease | | Natural | | Home | |
| DATE OF DEATH | | TIME OF DEATH | | HOURS OF DEATH | | MINUTES OF DEATH | | SECONDS OF DEATH | |
| Jan 20, 1945 | | 10:30 AM | | 10 | | 30 | | 00 | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | | SIGNATURE OF FUNERAL HOME | | SIGNATURE OF REGISTRAR | |
| J. M. Smith | | J. M. Smith | | J. M. Smith | | J. M. Smith | | J. M. Smith | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| Jan 20, 1945 | | Jan 20, 1945 | | Jan 20, 1945 | | Jan 20, 1945 | | Jan 20, 1945 | |

STATE OF MARYLAND

13585

CERTIFICATE OF DEATH

13576

Reg. Dist. No.

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pennsylvania</i> b. COUNTY <i>York</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i> | | | | c. LENGTH OF STAY IN 1b <i>3 1/2 yrs</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Long View Nursing Home</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Livvie</i> Middle <i>Katherine</i> Last <i>Jordan</i> | | | | 4. DATE OF DEATH Month <i>December</i> Day <i>27</i> Year <i>1958</i> | | | |
| 5. SEX <i>Female</i> | | 6. COLOR OF RACE <i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>August 29, 1873</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>Victor Weaver</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Christine Reinhart</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT <i>Herbert V. Jordan Weaver Jr</i> Address <i></i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1 Atherosclerotic Cardiovascular Disease</i> DUE TO (b) <i>Coronary Thrombosis</i> DUE TO (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i> | |
| 20f. (City or town) <i></i> (County) <i></i> (State) <i></i> | | | | | | | |
| 21. I certify that I attended the deceased from <i>April 29, 1955</i> , to <i>Dec 27, 1958</i> , that I last saw the deceased alive on <i>Dec 26, 1958</i> , and that death occurred at <i>8 P. M.</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Joseph E. Bush</i> M.D. | | | | ADDRESS (Street, city or town, state) <i>Hampstead Maryland</i> DATE SIGNED <i>12-27-58</i> | | | |
| PHYSICIAN'S NAME (Type) <i>Joseph E. Bush M.D.</i> | | | | <i>HAMPSTEAD Maryland</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>12/30/58</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>St. Charles</i> | | 22d. LOCATION (City, town, or county) (State) <i>Hampstead Pa York Co</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Fredrick Bucher</i> ADDRESS <i>Hannover Pa</i> | | | | 24a. REC'D BY REGISTRAR DATE <i>DEC 30 '58</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoma</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13577

Reg. Dist. No.

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 6y. 3m. 15d. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MARTHA ELIZABETH PORTER KEEN | | 4. DATE OF DEATH Month December Day 12 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 5, 1868 |
| 9. AGE (in years last birthday) yrs. 90 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Robert Porter | | 14. MOTHER'S MAIDEN NAME Caroline Loar | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Records, Springfield State Hospital | |
| 17. INFORMANT Records, Springfield State Hospital | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422d DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, moderately advanced, inactive C.B.S. assoc. with senile brain disease, with psychotic reaction | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH Years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 002X | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 7, 1955 , to December 12, 1958 , that I last saw the deceased alive on December 12, 1958 , and that death occurred at 1:45 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12-12-58 | | | |
| ACTUAL SIGNATURE Agustin del Campo | | M.D. Springfield State Hospital | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M. D. | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/15/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Friendship Meth. Church | | 22d. LOCATION (City, town, or county) (State) Fallston, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran | | ADDRESS -3000 E. Baltimore St. | |
| 24a. REC'D BY REGISTRAR DATE DEC 15 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur L. K... | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

| | | | |
|------------------------------------------------------|--|-------------------------------------------------------|--|
| <p>1. Name of deceased: <u>JOHN J. BROWN</u></p> | | <p>2. Sex: <u>Male</u></p> | |
| <p>3. Date of birth: <u>1915</u></p> | | <p>4. Place of birth: <u>NEW YORK</u></p> | |
| <p>5. Date of death: <u>1975</u></p> | | <p>6. Place of death: <u>NEW YORK</u></p> | |
| <p>7. Cause of death: <u>Heart Disease</u></p> | | <p>8. Manner of death: <u>Natural</u></p> | |
| <p>9. Signature of physician: <u>[Signature]</u></p> | | <p>10. Signature of registrar: <u>[Signature]</u></p> | |
| <p>11. Date of registration: <u>1975</u></p> | | <p>12. Place of registration: <u>NEW YORK</u></p> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13587

CERTIFICATE OF DEATH

Reg. Dist. No.

13578

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton | | | | c. LENGTH OF STAY IN 1b 262 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | | | e. STREET ADDRESS Elizabeth Street | | | |
| 3. NAME OF DECEASED (Type or print) First Daniel Middle Keys Last Keys | | | | 4. DATE OF DEATH Month December Day 14 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-22-1906 | 9. AGE (In years last birthday) 52 yrs. | IF UNDER 1 YEAR Months 11 Days 14 Hours 14 Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Middlesex, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Hezekiah Keys | | | | 14. MOTHER'S MAIDEN NAME Annie Keys? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218-61-5327 | | 17. INFORMANT Daniel Keys - Patient | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO (b) Carcinoma of both lungs DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 27, 19 58 , to Dec. 14, 19 58 , that I last saw the deceased alive on Dec. 14, 19 58 , and that death occurred at 5:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton State Hospital DATE SIGNED 12-14-58 | | | | | | | |
| ACTUAL SIGNATURE E. M. Maculans M.D. | | M.D. Henryton State Hospital | | | | | |
| PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D. | | Henryton, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 1 | | 22b. DATE THEREOF 12-19-58 | | 22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell | | | | ADDRESS 1111 W. Baltimore Ave. | | 24a. REC'D BY REGISTRAR DEC 24 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use in burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13588

CERTIFICATE OF DEATH

Reg. Dist. No. **13579**

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| 1. PLACE OF DEATH a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 0143.2 ✓ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS Westernport | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Harry Middle Eugene Last Kooken | | 4. DATE OF DEATH Month December Day 3 Year 1958 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/23/03 | 9. AGE (In years last birthday) 55 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Crane Opr. | | 10b. KIND OF BUSINESS OR INDUSTRY Ynk | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Warren Kooken | | 14. MOTHER'S MAIDEN NAME Ethel C. Snyder | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. Ynk | | 17. INFORMANT Springfield State Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute thrombosis of the left leg. 453.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Berger's Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia reaction, other and unspecified | | | | INTERVAL BETWEEN ONSET AND DEATH minutes years. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/7 , 19 55 , to 12/3 , 19 58 , that I last saw the deceased alive on 12/3/58 , 19 58 , and that death occurred at 9:15a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12/3/58 | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo | | M.D. Springfield State Hospital 12/3/58 | | | | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | Sykesville, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-6-58 | | 22c. NAME OF CEMETERY OR CREMATORY Philox | | 22d. LOCATION (City, town, or county) (State) Westernport, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Kudlock Funeral Home | | | | ADDRESS Richmont W. Va. | | 24a. REC'D BY REGISTRAR DATE DEC 8 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Knaus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---------------------------------------------------------------------------|--|----------------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| <p>1. NAME OF DECEASED _____</p> | | <p>2. SEX _____</p> | | <p>3. AGE _____</p> | |
| <p>4. DATE OF DEATH _____</p> | | <p>5. TIME OF DEATH _____</p> | | <p>6. PLACE OF DEATH _____</p> | |
| <p>7. OCCUPATION _____</p> | | <p>8. CAUSE OF DEATH _____</p> | | <p>9. MANNER OF DEATH _____</p> | |
| <p>10. SIGNATURE OF PHYSICIAN _____</p> | | <p>11. SIGNATURE OF CORONER _____</p> | | <p>12. SIGNATURE OF WITNESS _____</p> | |
| <p>13. SIGNATURE OF DECEASED _____</p> | | <p>14. SIGNATURE OF NEXT OF KIN _____</p> | | <p>15. SIGNATURE OF BURIAL SOCIETY _____</p> | |
| <p>16. SIGNATURE OF MINISTER OF THE GOSPEL _____</p> | | <p>17. SIGNATURE OF CHURCH _____</p> | | <p>18. SIGNATURE OF FUNERAL HOME _____</p> | |
| <p>19. SIGNATURE OF COUNTY CLERK _____</p> | | <p>20. SIGNATURE OF STATE CLERK _____</p> | | <p>21. SIGNATURE OF DEPARTMENT OF HEALTH _____</p> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13589

CERTIFICATE OF DEATH

13580

Reg. Dist. No.

| | | | |
|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | c. LENGTH OF STAY IN 1b 1yr. 10mos. 12days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville 10x-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS None | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Florence Middle Andrews Last Lipps | | 4. DATE OF DEATH Month December Day 23 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 4, 1880 |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR Months 78 | IF UNDER 24 HRS. Days 78 Hours 78 Min. 78 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Charles Andrews | |
| 14. MOTHER'S MAIDEN NAME Emma Klise | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Springfield Hospital Records | |

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Generalized arteriosclerosis DUE TO (c) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction. | | INTERVAL BETWEEN ONSET AND DEATH Years Years. |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hospital |
| 20f. (City or town) Springfield | | (County) Frederick (State) Maryland |
| 21. I certify that I attended the deceased from February 11, 1957 to December 23, 1958 , that I last saw the deceased alive on December 22, 1958 , and that death occurred at 7:00A M, from the causes and on the date stated above. | | |
| ACTUAL SIGNATURE Edmund Lusthaus M.D. | | DATE SIGNED 12/23/58 |
| PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. | | Sykesville, Maryland |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 12-27-58 | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery |
| 22d. LOCATION (City, town, or county) Frederick, Maryland | | (State) Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR DEC 29 1958 |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Knaus | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13590

CERTIFICATE OF DEATH

Reg. Dist. No.

13581

| | | | |
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| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD Md</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>22 N. MAIN ST</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MAMIE GRAY Lippy</u> | | 4. DATE OF DEATH Month Day Year <u>December 20 1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 2, 1873</u> |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>FRANCIS LUCAS HANN</u> | | 14. MOTHER'S MAIDEN NAME <u>GARY Price</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>218-34-0453</u> | |
| 17. INFORMANT Address <u>Mrs Helen Lippy Goriett, HAMPSTEAD Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Septal Coronary Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 19 1954</u> to <u>Dec 20 1958</u> , that I last saw the deceased alive on <u>December 19 1958</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D. | | ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>12-20-58</u> | |
| PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u> | | <u>HAMPSTEAD Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12-22-1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u> | 22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin E. Kipton</u> | | ADDRESS <u>Hampstead Md</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>DEC 22 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13591

CERTIFICATE OF DEATH

13582

Reg. Dist. No.

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 2yrs. 7mos. 9days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital | | | | d. STREET ADDRESS 2325 E. Fayette St. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Elizabeth Middle Katherine Last Rauh Luckert | | | | 4. DATE OF DEATH Month December Day 19 Year 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 5, 1886 | |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME John Rauh | | | | 14. MOTHER'S MAIDEN NAME Mary Kruger | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with brain trauma, gross force, with psychotic reaction. 441X | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Years Days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 10, 1956 , to December 19, 1958 , that I last saw the deceased alive on December 18, 1958 , and that death occurred at 3:36 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Edmund Lusthaus | | | | ADDRESS (Street, city or town, state) Springfield Hospital | | DATE SIGNED 12/19/58 | |
| PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 12/22/58 | | 22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM. | | 22d. LOCATION (City, town, or county) (State) BALTO., MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Barley Miller | | | | ADDRESS 2334 Jefferson St. | | 24a. REC'D BY REGISTRAR DEC 23 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13592

CERTIFICATE OF DEATH

Reg. Dist. No. 13583

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| 1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> | | | | c. LENGTH OF STAY IN 1b <u>1yr 10mo. 4 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> 13X-2 | | | |
| f. STREET ADDRESS <u>42 Main Street</u> | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Rose</u> Last <u>Schrod</u> <u>MADEN</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-28-70</u> | |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Charles Schrod</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Katherine</u> - ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unk.</u> | | 17. INFORMANT <u>S.S.H. records</u> | | Address <u>Sykesville, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic brain syndrome associated with arterio-sclerosis.</u> DUE TO (c) <u> </u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> Years <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with arteriosclerosis with psychotic reaction.</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>January 29, 1957</u> , to <u>December 3, 1958</u> , that I last saw the deceased alive on <u>December 3, 1958</u> , and that death occurred at <u>4:25 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Ilse Kamm</u> | | | | ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Ilse Kamm, M. D.</u> | | | | DATE SIGNED <u>12-4-58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>12-8-58</u> | | <u>New Catholic</u> | | <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> | | | | ADDRESS <u>Sykesville, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 10 '58</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Charles E. H.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13593 CERTIFICATE OF DEATH

13584

Reg. Dist. No.

| | | | |
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| 1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WESTMINSTER | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - WESTMINSTER | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 1 d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First IRENE Middle LORRAINE Last MCLEMORE | | 4. DATE OF DEATH Month DEC Day 18 Year 1958 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APR 13, 1898 |
| 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY House wife | 11. BIRTHPLACE (State or foreign country) New York, N. Y. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Herbert Bell | |
| 14. MOTHER'S MAIDEN NAME Ida. Green. | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 090-07-299A | | 17. INFORMANT PAUL RAY McLEMORE Westminister Rd #1 Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 170x DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) CEREBRAL CARCINOMA, METASTATIC DUE TO (c) ADENOCARCINOMA OF RIGHT BREAST | | INTERVAL BETWEEN ONSET AND DEATH 8 MO. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) VALVULAR HEART DISEASE | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. f. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from MAY 9, 1958 , to DEC 16, 1958 , that I last saw the deceased alive on DEC 16, 1958 , and that death occurred at 3 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Donald E. Withers | | ADDRESS (Street, city or town, state) 205 E. WALNUT ST. | |
| PHYSICIAN'S NAME (Type) DONALD E. WITHERS, M.D. | | DATE SIGNED 12/19/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) cremation | | 22b. DATE THEREOF 12/20/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Charles Evans Cemetery | | 22d. LOCATION (City, town, or county) (State) Reading, Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. E. Meyer, Jr. Westminister, Md. | | 24. REC'D BY REGISTRAR DEC 22 '58 | |
| 24b. REGISTRAR'S SIGNATURE Charles E. Green | | | |

10-1-19

18993 CERTIFICATE OF DEATH

| | | | |
|--------------------------------------------|--|--------------------------------------------|--|
| 1. NAME OF DECEASED JAMES H. HARRIS | | 2. SEX Male | |
| 3. AGE 45 Years | | 4. DATE OF DEATH Jan 1, 1900 | |
| 5. PLACE OF DEATH Baltimore, Md. | | 6. CAUSE OF DEATH Heart Disease | |
| 7. OCCUPATION Clerk | | 8. RESIDENCE 1234 N. Main St. | |
| 9. MARITAL STATUS Married | | 10. EDUCATION High School | |
| 11. RELIGION Protestant | | 12. COLOR White | |
| 13. BIRTH DATE Dec 15, 1854 | | 14. BIRTH PLACE Baltimore, Md. | |
| 15. FATHER'S NAME John H. Harris | | 16. MOTHER'S NAME Mary E. Harris | |
| 17. PREVIOUS ILLNESS None | | 18. TIME OF DEATH 10:30 AM | |
| 19. SIGNATURE OF PHYSICIAN J. H. Harris | | 20. SIGNATURE OF REGISTRAR J. H. Harris | |
| 21. PLACE OF BURIAL St. Paul's Church | | 22. GRAVE NUMBER 1234 | |

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the coroner, or by the registrar, or by the undertaker, or by the person who has taken charge of the funeral. It is to be filled out in duplicate, one copy to be retained by the registrar, and the other copy to be sent to the State Department of Health, Baltimore, Md.

13594 CERTIFICATE OF DEATH

Reg. Dist. No. 13585

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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 2yrs. 4mos. 6days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS None | |
| 3. NAME OF DECEASED (Type or print) First Annie Middle Frances Last Miller Michaels | | 4. DATE OF DEATH Month December Day 23 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 24, 1886 |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Unknown | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Noah Miller | | 14. MOTHER'S MAIDEN NAME Mary Kyles | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE OF DEATH (Enter in Part II of item 18.) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction. | | | |
| INTERVAL BETWEEN ONSET AND DEATH Years Years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from August 17, 1956 to December 23, 1958 , that I last saw the deceased alive on December 22, 1958 , and that death occurred at 6:00 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12/23/58 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Buried | 22b. DATE THEREOF 01/13/26/58 | 22c. NAME OF CEMETERY OR CREMATORY Tas Ker Cemetery | 22d. LOCATION (City, town, or county) (State) Near Vindex Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE A. C. Leighton | | 24a. REC'D BY REGISTRAR DEC 29 '58 | 24b. REGISTRAR'S SIGNATURE Arthur E. Evans |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13586

13595 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton | | c. LENGTH OF STAY IN Ib 913 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | d. STREET ADDRESS 616 10th Street | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle Alphonza Last Nicholson | | 4. DATE OF DEATH Month December Day 28 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-3-1910 |
| 9. AGE (In years last birthday) 48 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Laurel, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Abraham Nicholson | | 14. MOTHER'S MAIDEN NAME Laura Heburn | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 705-07-7572 | |
| 17. INFORMANT Joseph Alphonza Nicholson - Patient | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitis and Alcoholism DUE TO (c) Far Advanced Bilateral Pulmonary Tuberculosis | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260X | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 28 , 19 56 , to December 28 , 19 58 , that I last saw the deceased alive on December 28 , 19 58 , and that death occurred at 6:15A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE E. M. Maculans | | DATE SIGNED 12-28-58 | |
| PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. | | ADDRESS (Street, city or town, state) Henryton, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec 31/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Bacone Chapel | | 22d. LOCATION (City, town, or county) (State) Anne Arundel Co Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R. SELBY, LAUREL, Md. | | 24a. REC'D BY REGISTRAR DATE DEC 30 1958 | |
| 24b. REGISTRAR'S SIGNATURE | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13596 CERTIFICATE OF DEATH

13588

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 4 m 21 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Harry Middle W. Last Pomarius | | | | 4. DATE OF DEATH Month 12 Day 13 Year 1958 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-7-71 | |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR Months 12 Days 13 Hours 19 Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer | | 11. BIRTHPLACE (State or foreign country) New York | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Philip Pomarius | | | | 14. MOTHER'S MAIDEN NAME Johanna | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unkn | | | | 16. SOCIAL SECURITY NO. unkn | | | |
| 17. INFORMANT S.S Hospital Records | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 491X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arterioscler. with psych. reaction Arteriosclerotic cardiovase. disease, Urinary infection 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 7-22-, 1958 , to 12-12-, 1958 , that I last saw the deceased alive on 12-12-, 1958 , and that death occurred at 5:30A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 12-13-58 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. Sykesville, Maryland. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Dec. 16, 1958 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery 22d. LOCATION (City, town, or county) (State) Baltimore Maryland 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc. ADDRESS 1217 St. Paul Street 24a. REC'D BY REGISTRAR DEC 17 58 DATE 24b. REGISTRAR'S SIGNATURE Edmund S. Mous | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MANHATTAN STATE DEPARTMENT OF HEALTH-BALTIMORE 10

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

INTERMEDIATE CAUSE OF DEATH

PRE-EXISTING DISEASES

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

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DATE OF BIRTH OF CHILD

NAME OF CHILD

DATE OF BIRTH OF CHILD

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13598 CERTIFICATE OF DEATH

13590

Reg. Dist. No. 74

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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton, Maryland | | | | c. LENGTH OF STAY IN 1b 922 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | | | d. STREET ADDRESS 303 Tompkins Court | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle N. Last Rice | | | | 4. DATE OF DEATH Month December Day 29 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 30, 1918 | | 9. AGE (In years last birthday) 40 yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | | 11. BIRTHPLACE (State or foreign country) Fairfield, S. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Rice | | | | 14. MOTHER'S MAIDEN NAME Beatrice Coleman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218-07-3556 | | 17. INFORMANT Joseph N. Rice - Patient | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral cavitary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 20, 19 56 , to December 29, 19 58 , that I last saw the deceased alive on Dec. 29, 19 58 , and that death occurred at 1:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 12-29-58 | | | | | | | |
| ACTUAL SIGNATURE E. M. Maculans, M. D. M.D. | | | | DATE SIGNED 12-29-58 | | | |
| PHYSICIAN'S NAME (Type) E. M. Maculans, M. D. | | | | Henryton State Hospital | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 1/4/59 | | 22c. NAME OF CEMETERY OR CREMATORY Family Lot | | 22d. LOCATION (City, town, or county) (State) Chesley St | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home | | | | ADDRESS 1631 Spring Hill Ave | | 24a. REC'D BY REGISTRAR DATE JAN 2 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraw | | | |

13298 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

13298

Age 50 M

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF DEPARTURE FROM STATE

DATE OF RETURN TO STATE

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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13599 CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 6 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First HELEN Middle VERDE Last ROSS | | | | 4. DATE OF DEATH Month December Day 11 Year 1958 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 12, 1892 | | 9. AGE (In years last birthday) 66 ? yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof Reader | | 10b. KIND OF BUSINESS OR INDUSTRY Relief Pub. Coun. | | 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Ross | | | | 14. MOTHER'S MAIDEN NAME Helen | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Records, Springfield State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Urinary tract infection DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute brain syndrome associated with metabolic disturbance (uremia) Diabetes mellitus | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Days Days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 260X | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that I attended the deceased from December 5, 1958 , to December 11, 1958 , that I last saw the deceased alive on December 11, 1958 , and that death occurred at 4:00 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo M.D. | | | | ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12-11-58 | | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec 12, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON CEM | | 22d. LOCATION (City, town, or county) (State) RIGGS RD. AVATTSVILLE, MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles S. K... 254 Carroll St. NW. | | | | 24a. REC'D BY REGISTRAR DEC 15 1958 | | 24b. REGISTRAR'S SIGNATURE Charles S. K... | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13600

CERTIFICATE OF DEATH

13592

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY ----- | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3 Vol 4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mae Pullen Nursing Home</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Emma</i> First <i>M</i> Middle <i>Scherer</i> Last | | 4. DATE OF DEATH <i>December 22nd</i> 19 <i>58</i> | |
| 5. SEX <i>female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Feb. 22, 1883</i> |
| 9. AGE (In years last birthday) <i>75</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Germany</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>Germany</i> | |
| 13. FATHER'S NAME <i>Frederick Bugge</i> | | 14. MOTHER'S MAIDEN NAME <i>?</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Mrs. Ella Wortham, 2900 Southern Ave.</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension, arteriosclerosis,</i> 331X DUE TO <i>massive cerebral hemorrhage.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>pulmonary edema.</i> (c) <i>pulmonary edema.</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>19.57 to 22 Dec 58</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>1957</i> to <i>Dec 1958</i> , that I last saw the deceased alive on <i>22 Dec 1958</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Howard E. Hall</i> M.D. | | ADDRESS (Street, city or town, state) <i>Agnew, Md</i> DATE SIGNED <i>22 Dec 58</i> | |
| PHYSICIAN'S NAME (Type) <i>Howard E. Hall</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>12/24/58</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i> | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i> | | 24a. REC'D BY REGISTRAR <i>DEC 24 58</i> DATE | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Christina L. Travis</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13601 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural) | | | | c. LENGTH OF STAY IN 1b 28 y. 8 m. 5 d. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS Unknown | | | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle V Last Sessums | | | | 4. DATE OF DEATH Month December Day 12 Year 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 16, 1891 | |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR Months 67 Days 12 Hours 12 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Virginia | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Edwin H. Russell | | | | 14. MOTHER'S MAIDEN NAME Mary Boyd | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. Springfield State Hospital Record | | | |
| 17. INFORMANT Springfield State Hospital Record | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Degeneration DUE TO years (c) Severe Gangrenous Ulceration DUE TO Days | | | | INTERVAL BETWEEN ONSET AND DEATH Weeks | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with Mental Deficiency | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month 19 Day 19 Year 1958 Hour 19 a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from November 18 1958 , to December 12, 1958 , that I last saw the deceased alive on December 12, 1958 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Konstantin Weber | | | | ADDRESS (Street, city or town, state) Springfield State Hospital | | | |
| DATE SIGNED 12/12/58 | | | | | | | |
| PHYSICIAN'S NAME (Type) Konstantin Weber, M. D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 12-15-1958 | | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State) Bladensburg Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. | | | | ADDRESS River Dale Md. | | | |
| 24a. REC'D BY REGISTRAR DEC 17 '58 | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kneel | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13093

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

13093

Reg. Div. 10

| | | | |
|---------------------------------------------|--|-------------------------------------------|--|
| 1. NAME OF DECEASED JAMES H. HARRIS | | 2. SEX Male | |
| 3. AGE 65 | | 4. RACE White | |
| 5. DATE OF DEATH April 12, 1968 | | 6. PLACE OF DEATH Home | |
| 7. CITY Baltimore | | 8. COUNTY Baltimore | |
| 9. STATE Maryland | | 10. ZIP CODE 21201 | |
| 11. MARITAL STATUS Married | | 12. OCCUPATION Retired | |
| 13. CAUSE OF DEATH Myocardial Infarction | | 14. MANNER OF DEATH Natural | |
| 15. SIGNATURE OF PHYSICIAN [Signature] | | 16. SIGNATURE OF REGISTRAR [Signature] | |
| 17. DATE OF SIGNATURE April 15, 1968 | | 18. OFFICIAL USE [Stamp] | |

ORIGINAL FILED IN 13093

13093-12-12-1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13594

13604 CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WESTMINSTER | | c. LENGTH OF STAY IN 1b 43 YEARS x WESTMINSTER (RURAL) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FINKS BURG, MD, RD #1 | | d. STREET ADDRESS 1 FINKS BURG, MD, RD #1 | |
| 3. NAME OF DECEASED (Type or print) First RAYMOND Middle LESLIE Last SHILLING | | 4. DATE OF DEATH Month DECEMBER Day 26 Year 1958 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DECEMBER 25, 1889 69 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER CANNER | | 10b. KIND OF BUSINESS OR INDUSTRY FARMER - CANNING | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 13. FATHER'S NAME RICHARD THOMAS SHILLING | | 14. MOTHER'S MAIDEN NAME MARY ELIZABETH HAFLEIGH | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. R17-28 5672 | |
| 17. INFORMANT RICHARD SHILLING (SON) | | Address WESTMINSTER MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from SEPTEMBER 1958 , to DECEMBER 1958 , that I last saw the deceased alive on DECEMBER 23, 1958 , and that death occurred at 2:35 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Daniel D Welliver M.D. | | ADDRESS (Street, city or town, state) 19 N. CHURCH ST WESTMINSTER MARYLAND | |
| PHYSICIAN'S NAME (Type) DANIEL D. WELLIVER | | DATE SIGNED 12-26-58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF DEC. 29 58 | 22c. NAME OF CEMETERY OR CREMATORY CARROLLTON CHURCH CEM. Finksburg Md, RD #1 | 22d. LOCATION (City, town, or county) _____ (State) _____ |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr., Westminster Md | | 24a. REC'D BY REGISTRAR DEC 30 '58 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

RAYMOND J. WESTMINSTER
 DECEMBER 23, 1928
 22 WESTMINSTER ST
 BOSTON, MASS.

RAYMOND J. WESTMINSTER
 DECEMBER 23, 1928
 22 WESTMINSTER ST
 BOSTON, MASS.

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 DECEMBER 23, 1928
 22 WESTMINSTER ST
 BOSTON, MASS.

RAYMOND J. WESTMINSTER
 DECEMBER 23, 1928
 22 WESTMINSTER ST
 BOSTON, MASS.

RAYMOND J. WESTMINSTER
 DECEMBER 23, 1928
 22 WESTMINSTER ST
 BOSTON, MASS.

13605 CERTIFICATE OF DEATH

Reg. Dist. No:

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| 1. PLACE OF DEATH a. COUNTY Garroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 1yr. 8mo. 11days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Ruth Middle Elizabeth Last Shoemaker | | | | 4. DATE OF DEATH Month December Day 3 Year 19 58 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12/12/93 | |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Work | | | | 10b. KIND OF BUSINESS, OR INDUSTRY U.S. Govt. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William Shoemaker | | | | 14. MOTHER'S MAIDEN NAME Sarah Perry | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. 214-30-0444 | | 17. INFORMANT Springfield Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circulatory disturbance with psychotic reaction. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/22 , 19 57 , to 12/2 , 19 58 , that I last saw the deceased alive on 12/2 , 19 58 , and that death occurred at 5:15a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edmund Lusthaus Springfield State Hospital 12/3/58 M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | |
| 22b. DATE THEREOF 12-6-58 | | 22c. NAME OF CEMETERY OR CREMATORY Rockville Union | | 22d. LOCATION (City, town, or county) (State) Rockville, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lusthaus ADDRESS Springfield State Hospital, Md. | | | | | | | |
| 24a. REC'D BY REGISTRAR DEC 8 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13602 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13597

Reg. Dist. No.

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Fredrick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u> 10x-2 | |
| c. LENGTH OF STAY IN 1b <u>less than 1 day</u> | | d. STREET ADDRESS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Charles</u> Last <u>Smith</u> | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>1958</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/22/1919</u> 39 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 11. BIRTHPLACE (State or foreign country) <u>U. S. A. Maryland</u> | |
| 13. FATHER'S NAME <u>Clarence Smith</u> | | 14. MOTHER'S MAIDEN NAME <u>Nellie Margaret Poole</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 1942-1945 | | 16. SOCIAL SECURITY NO. <u>36-07-6500</u> | |
| 17. INFORMANT <u>Hospital records</u> Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral lobular pneumonia</u> 491x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Brinn Syndrome, on, with Alcohol Intoxication</u> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>James J. Marsh</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>12/25/58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/20/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Bothel</u> | | 22d. LOCATION (City, town, or county) (State) <u>Hantz #1 Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grove</u> ADDRESS <u>Waynesboro Pa</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Clifford P. ...</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
13800 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE DEPARTMENT OF HEALTH
BUREAU OF
MORTUARY
SERVICES
Baltimore, Maryland

| | | | | | |
|-----------------------------|--|--------------------------|--|-------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. RACE | | 5. OCCUPATION | | 6. MARITAL STATUS | |
| 7. PLACE OF BIRTH | | 8. PLACE OF DEATH | | 9. DATE OF DEATH | |
| 10. TIME OF DEATH | | 11. CAUSE OF DEATH | | 12. MANNER OF DEATH | |
| 13. SIGNATURE OF EXAMINER | | 14. SIGNATURE OF WITNESS | | 15. SIGNATURE OF FUNERAL HOME | |
| 16. SIGNATURE OF CORONER | | 17. SIGNATURE OF JURY | | 18. SIGNATURE OF JUDGE | |
| 19. SIGNATURE OF PROSECUTOR | | 20. SIGNATURE OF DEFENSE | | 21. SIGNATURE OF JURY | |
| 22. SIGNATURE OF JUDGE | | 23. SIGNATURE OF JURY | | 24. SIGNATURE OF JURY | |
| 25. SIGNATURE OF JURY | | 26. SIGNATURE OF JURY | | 27. SIGNATURE OF JURY | |
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| 70. SIGNATURE OF JURY | | 71. SIGNATURE OF JURY | | 72. SIGNATURE OF JURY | |
| 73. SIGNATURE OF JURY | | 74. SIGNATURE OF JURY | | 75. SIGNATURE OF JURY | |
| 76. SIGNATURE OF JURY | | 77. SIGNATURE OF JURY | | 78. SIGNATURE OF JURY | |
| 79. SIGNATURE OF JURY | | 80. SIGNATURE OF JURY | | 81. SIGNATURE OF JURY | |
| 82. SIGNATURE OF JURY | | 83. SIGNATURE OF JURY | | 84. SIGNATURE OF JURY | |
| 85. SIGNATURE OF JURY | | 86. SIGNATURE OF JURY | | 87. SIGNATURE OF JURY | |
| 88. SIGNATURE OF JURY | | 89. SIGNATURE OF JURY | | 90. SIGNATURE OF JURY | |
| 91. SIGNATURE OF JURY | | 92. SIGNATURE OF JURY | | 93. SIGNATURE OF JURY | |
| 94. SIGNATURE OF JURY | | 95. SIGNATURE OF JURY | | 96. SIGNATURE OF JURY | |
| 97. SIGNATURE OF JURY | | 98. SIGNATURE OF JURY | | 99. SIGNATURE OF JURY | |
| 100. SIGNATURE OF JURY | | 101. SIGNATURE OF JURY | | 102. SIGNATURE OF JURY | |

13606

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> | | c. LENGTH OF STAY IN 1b <u>YEARS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>RURAL</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE LOUISE SMITH</u> | | 4. DATE OF DEATH Month Day Year <u>DEC 27 1958</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>COLORED</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/11/1896</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>WILLIAM BRIGHTFUL</u> | | 14. MOTHER'S MAIDEN NAME <u>MARTHA BRIGHTFUL</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>HENRY CLAY SMITH</u> | | Address <u>UNION BRIDGE MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocarditis</u> 550.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute appendicitis Peritonitis</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Nov. 16, 1958</u> , to <u>12-26-1958</u> , that I last saw the deceased alive on <u>12-26-1958</u> , and that death occurred at <u>3 A.</u> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>J. H. Legg</u> M.D. | | ADDRESS (Street, city or town, state) <u>Union Bridge</u> DATE SIGNED <u>12-27-58</u> | |
| PHYSICIAN'S NAME (Type) <u>T. H. WEGGINS</u> | | <u>UNION BRIDGE, MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>12/29/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE</u> | 22d. LOCATION (City, town, or county) (State) <u>FREDERICK COUNTY MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Harkley & Sons, Union Bridge Md</u> | | 24a. REC'D BY REGISTRAR <u>DEC 30 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13603

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

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| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | c. LENGTH OF STAY IN 1b <u>1 yr</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u> | | | | d. STREET ADDRESS <u>821 Union Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Laura Belle Hoover</u> First Middle Last | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1958</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-21-74</u> | 9. AGE (In years last birthday) <u>84</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country) <u>Tennessee</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Wm Hoover</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Remily J. Steffy</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <u>Hospital Records</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia -</u> <u>609x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Urinary Tract Infection</u> (a), stating the underlying cause last. <u>902.7</u> DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>?</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arterio Sclerosis with psychotic reaction - Free left hip</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from chair</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11:30</u> 19 <u>58</u> p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>S.S.H.</u> | 20f. (City or town) <u>Sykesville</u> | (County) <u>Carroll</u> | (State) <u>Md</u> | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>James T. Marsh</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>JAMES T MARSH</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, or other disposition <u>Burial</u> | | 22b. DATE THEREOF <u>Dec 11, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St Marys (Hampden)</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Horace P. Bungee</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>DEC 10 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kears</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13607

CERTIFICATE OF DEATH

13599

Reg. Dist. No.

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (28) 0352.2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital | | d. STREET ADDRESS 904 Prestwood Rd. | |
| 3. NAME OF DECEASED (Type or print) First Sylvester Middle Stockbridge Last | | 4. DATE OF DEATH Month December Day 22 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 7, 1905 |
| 9. AGE (In years last birthday) yrs. 53 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Jason W. Stockbridge | | 14. MOTHER'S MAIDEN NAME Cora Bowersock | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH Years Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, paranoid type. | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from March 7, 1955 , to December 22, 1958 , that I last saw the deceased alive on December 21, 1958 , and that death occurred at 12:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12/22/58 | | | |
| ACTUAL SIGNATURE Agustin del Campo M.D. | | DATE SIGNED 12/22/58 | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Dec. 23, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Landon Park | 22d. LOCATION (City, town, or county) (State) Balto Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE John T. Gensel | | 24a. REC'D BY REGISTRAR DATE DEC 23 '58 | |
| ADDRESS 5311 Edmondson Ave | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13608

CERTIFICATE OF DEATH

Reg. Dist. No.

14425

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Carroll</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | | | c. LENGTH OF STAY IN 1b <u>11yrs. 10mos. 25days</u> <u>Baltimore</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u> | | | | d. STREET ADDRESS <u>711 S. Broadway</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Kelly</u> Middle <u>Stoeoff</u> Last <u>Stoeoff</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>Unknown</u> <input type="checkbox"/> FORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Unknown</u> | |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipyard worker</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>Turkey</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>Turkey</u> | | | | | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u> | | | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Springfield Hospital Records</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic lymphatic leukemia</u> <u>2040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Syphilitic meningo-encephalitis.</u> <u>025X</u> INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>March 7, 1955</u> to <u>December 30, 1958</u> that I last saw the deceased alive on <u>December 29, 1958</u> , and that death occurred at <u>1:30A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield Hospital</u> DATE SIGNED <u>12/30/58</u> ACTUAL SIGNATURE <u>Agustin del Campo</u> M.D. <u>Springfield Hospital</u> PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u> <u>Sykesville, Maryland.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>12.31.58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. H. Jewell</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JAN 7 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Robert S. Thrall</u> | |

1432

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

1900

Reg. Dist. No.

| | | | | | | | |
|--------------------------|--|----------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | |
| John A. Jones | | Male | | 35 | | Jan 1, 1865 | |
| 5. PLACE OF BIRTH | | 6. OCCUPATION | | 7. CAUSE OF DEATH | | 8. PLACE OF DEATH | |
| New York City | | Clerk | | Heart Disease | | Home | |
| 9. DATE OF DEATH | | 10. TIME OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
| Jan 15, 1900 | | 10:00 AM | | [Signature] | | [Signature] | |
| 13. NAME OF FUNERAL HOME | | 14. NAME OF MINISTER | | 15. NAME OF CHURCH | | 16. NAME OF CEMETERY | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 17. NAME OF NEXT OF KIN | | 18. NAME OF WITNESS | | 19. NAME OF WITNESS | | 20. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 21. NAME OF WITNESS | | 22. NAME OF WITNESS | | 23. NAME OF WITNESS | | 24. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 25. NAME OF WITNESS | | 26. NAME OF WITNESS | | 27. NAME OF WITNESS | | 28. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 29. NAME OF WITNESS | | 30. NAME OF WITNESS | | 31. NAME OF WITNESS | | 32. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 33. NAME OF WITNESS | | 34. NAME OF WITNESS | | 35. NAME OF WITNESS | | 36. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 37. NAME OF WITNESS | | 38. NAME OF WITNESS | | 39. NAME OF WITNESS | | 40. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 41. NAME OF WITNESS | | 42. NAME OF WITNESS | | 43. NAME OF WITNESS | | 44. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 45. NAME OF WITNESS | | 46. NAME OF WITNESS | | 47. NAME OF WITNESS | | 48. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 49. NAME OF WITNESS | | 50. NAME OF WITNESS | | 51. NAME OF WITNESS | | 52. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 53. NAME OF WITNESS | | 54. NAME OF WITNESS | | 55. NAME OF WITNESS | | 56. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 57. NAME OF WITNESS | | 58. NAME OF WITNESS | | 59. NAME OF WITNESS | | 60. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 61. NAME OF WITNESS | | 62. NAME OF WITNESS | | 63. NAME OF WITNESS | | 64. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 65. NAME OF WITNESS | | 66. NAME OF WITNESS | | 67. NAME OF WITNESS | | 68. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 69. NAME OF WITNESS | | 70. NAME OF WITNESS | | 71. NAME OF WITNESS | | 72. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 73. NAME OF WITNESS | | 74. NAME OF WITNESS | | 75. NAME OF WITNESS | | 76. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 77. NAME OF WITNESS | | 78. NAME OF WITNESS | | 79. NAME OF WITNESS | | 80. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 81. NAME OF WITNESS | | 82. NAME OF WITNESS | | 83. NAME OF WITNESS | | 84. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 85. NAME OF WITNESS | | 86. NAME OF WITNESS | | 87. NAME OF WITNESS | | 88. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 89. NAME OF WITNESS | | 90. NAME OF WITNESS | | 91. NAME OF WITNESS | | 92. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 93. NAME OF WITNESS | | 94. NAME OF WITNESS | | 95. NAME OF WITNESS | | 96. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |
| 97. NAME OF WITNESS | | 98. NAME OF WITNESS | | 99. NAME OF WITNESS | | 100. NAME OF WITNESS | |
| [Blank] | | [Blank] | | [Blank] | | [Blank] | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13609

CERTIFICATE OF DEATH

13600

Reg. Dist. No.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 1yr. 6mos. 24days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital | | | | d. STREET ADDRESS 2041 Ellsworth St. | | | |
| 3. NAME OF DECEASED (Type or print) First Edward Middle Joseph Last Stresewski | | | | 4. DATE OF DEATH Month December Day 18 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 9, 1879 | | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing Helper | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-01-6087 | | 17. INFORMANT Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphocytic leukemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I attended the deceased from May 24, 19 57 , to December 18, 19 58 , that I last saw the deceased alive on December 18, 19 58 , and that death occurred at 10:32P M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Edmund Lusthaus</i> | | | | ADDRESS (Street, city or town, state) Springfield State Hospital | | DATE SIGNED 12/19/58 | |
| PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 12/22/58 | | 22b. DATE THEREOF 12/22/58 | | 22c. NAME OF CEMETERY OR CREMATORY Mordant Park | | 22d. LOCATION (City, town, or county) (State) Balto Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Lemard Luck</i> | | | | ADDRESS 5305 Harford | | 24a. REC'D BY REGISTRAR DATE DEC 22 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Kneass</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13509

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH - DEATH

13509

| | | | |
|--------------------------------|--|---------------------|--|
| NAME OF DECEASED | | JAMES H. HARRIS | |
| AGE | | 35 | |
| SEX | | Male | |
| RACE | | White | |
| DATE OF BIRTH | | JAN 15 1900 | |
| PLACE OF BIRTH | | BALTIMORE, MARYLAND | |
| OCCUPATION | | Carpenter | |
| CAUSE OF DEATH | | Heart Disease | |
| DATE OF DEATH | | JAN 15 1935 | |
| PLACE OF DEATH | | BALTIMORE, MARYLAND | |
| SIGNATURE OF PHYSICIAN | | J. H. HARRIS | |
| SIGNATURE OF REGISTRAR | | J. H. HARRIS | |
| SIGNATURE OF WITNESSES | | J. H. HARRIS | |
| SIGNATURE OF DECEASED | | J. H. HARRIS | |
| SIGNATURE OF NEXT OF KIN | | J. H. HARRIS | |
| SIGNATURE OF CLERK | | J. H. HARRIS | |
| SIGNATURE OF JUDGE | | J. H. HARRIS | |
| SIGNATURE OF SHERIFF | | J. H. HARRIS | |
| SIGNATURE OF CORONER | | J. H. HARRIS | |
| SIGNATURE OF DISTRICT ATTORNEY | | J. H. HARRIS | |
| SIGNATURE OF COUNTY CLERK | | J. H. HARRIS | |
| SIGNATURE OF CITY CLERK | | J. H. HARRIS | |
| SIGNATURE OF VICE MAYOR | | J. H. HARRIS | |
| SIGNATURE OF MAYOR | | J. H. HARRIS | |

CHIEF CLERK

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13610 CERTIFICATE OF DEATH

13601

Reg. Dist. No.

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--------------------------------------------------|
| 1. PLACE OF DEATH o. COUNTY Carroll County MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rt. # 2) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Grandview Nursing Home | | | | d. STREET ADDRESS 4430 Pen Lucy Road #29 | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Hannah E. Thiel | | | | 4. DATE OF DEATH Month Day Year Dec. 18 19 58 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 25, 1872 | |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Dismas Schmidt | | | | 14. MOTHER'S MAIDEN NAME Fannie Roesche | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mrs. Hildegard Arnold-3504 Marmon Avenue | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 350x IMMEDIATE CAUSE (a) PARALYSIS AGITANS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5.15.56 , 19____, to 12.18.58 , 19____, that I last saw the deceased alive on 12.18.58 , 19____, and that death occurred at 8 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Liberty Road at Eldersburg DATE SIGNED 12/18/58 | | | | | | | |
| ACTUAL SIGNATURE Wm. H. Lawson, Jr., M.D. M.D. | | | | DATE SIGNED 12/18/58 | | | |
| PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D. | | | | Sykesville P.O., Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/22/58 | | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. ... ADDRESS Baltimore Md. | | | | 24a. REC'D BY REGISTRAR DATE 12/22/58 | | 24b. REGISTRAR'S SIGNATURE R. O. Williams | |

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13611

CERTIFICATE OF DEATH

13602

Reg. Dist. No.

| | | | | | | | |
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| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural Sykesville</u> | | | |
| c. LENGTH OF STAY IN 1b <u>Life</u> | | | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>CHRISTINE M. WILSON</u> | | | | 4. DATE OF DEATH <u>Dec. 27</u> 19 <u>58</u> | | | |
| 5. SEX <u>St.</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 2, 1883</u> | |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Jacob Magin</u> | | 14. MOTHER'S MAIDEN NAME <u>unk -</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Ms Clyde Wilson - Sykesville, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X CEREBRAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>DIABETES MELLITUS</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 years</u> <u>15 years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>1935</u> , 19 <u> </u> , to <u>26 December</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>25 December</u> , 19 <u>58</u> , and that death occurred at <u>12:02 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>12.26.58</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Wm. H. Lawson, Jr.</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>12-29-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial Gardens</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Frederick, Carroll Co., Md</u> | | | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Haight</u> ADDRESS <u>Sykesville, Md</u> | | | |
| 24a. REC'D BY REGISTRAR <u>DATE JAN 5 '59</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haight</u> | | | |

CERTIFICATE OF DEATH

13603

Reg. Dist. No.

13612

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural--Westminster</u> | | | | c. LENGTH OF STAY IN 1b <u>12 yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>M.</u> Last <u>ZILE</u> | | | | 4. DATE OF DEATH Month <u>DEC.</u> Day <u>10,</u> Year <u>1958</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-15-1903</u> | |
| 9. AGE (In years, lost birthday) <u>55</u> yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>William D. Zile</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Lovell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>?</u> | | 17. INFORMANT <u>Mr. F. A. Zile, Glencoe, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephritis acute</u> <u>590x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>Jan 4, 1949</u> to <u>Dec 10, 1958</u> , that I last saw the deceased alive on <u>Dec 10, 1958</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Julius Chopko</u> | | | | ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> | | DATE SIGNED <u>12/11/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Julius Chopko</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>12-13-1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u> | | 22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u> | | | | ADDRESS <u>Winfield, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DEC 15 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | 1990 | 2000 |
|-------------------------|------|------|
| 1. <i>Chrysomelids</i> | 10 | 10 |
| 2. <i>Curculionids</i> | 10 | 10 |
| 3. <i>Chrysomelids</i> | 10 | 10 |
| 4. <i>Chrysomelids</i> | 10 | 10 |
| 5. <i>Chrysomelids</i> | 10 | 10 |
| 6. <i>Chrysomelids</i> | 10 | 10 |
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| 73. <i>Chrysomelids</i> | 10 | 10 |
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| 75. <i>Chrysomelids</i> | 10 | 10 |
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| 85. <i>Chrysomelids</i> | 10 | 10 |
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| 87. <i>Chrysomelids</i> | 10 | 10 |
| 88. <i>Chrysomelids</i> | 10 | 10 |
| 89. <i>Chrysomelids</i> | 10 | 10 |
| 90. <i>Chrysomelids</i> | 10 | 10 |
| 91. <i>Chrysomelids</i> | 10 | 10 |
| 92. <i>Chrysomelids</i> | 10 | 10 |
| 93. <i>Chrysomelids</i> | 10 | 10 |
| 94. <i>Chrysomelids</i> | 10 | 10 |
| 95. <i>Chrysomelids</i> | 10 | 10 |
| 96. <i>Chrysomelids</i> | 10 | 10 |
| 97. <i>Chrysomelids</i> | 10 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13613 CERTIFICATE OF DEATH

Reg. Dist. No.

13604

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester (Rural)</u> | | c. LENGTH OF STAY IN 1b <u>10 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>WILLIAM</u> Last <u>ZUSE</u> | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 15 - 1877</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Minister</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Augustus Zuse</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Maisel</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>171-24-5524</u> | |
| 17. INFORMANT <u>Harry Zuse - Manchester Md</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>antemortem Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Embolism</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> | Month <u> </u> Day <u> </u> Year <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 14</u> 19 <u>48</u> , to <u>Dec 25</u> 19 <u>58</u> , that I last saw the deceased alive on <u>12-22</u> 19 <u>58</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W. H. Foard</u> M.D. | | DATE SIGNED <u>12-26-58</u> | |
| PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u> | | ADDRESS (Street, city or town, state) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>12-29-1958</u> | <u>New Freedom</u> | <u>York Co Penna</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C Tipton - Hampstead Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u> |

The image shows a document that has been almost entirely redacted with a large, thick black 'X'. The document appears to be a form or a letter, with various stamps and text visible around the perimeter of the redaction. At the top, there are some faint, illegible markings. On the right side, there are several rectangular stamps, some of which contain the word 'RECEIVED'. In the center, where the 'X' is, there is some faint, handwritten text that is mostly obscured. The overall appearance is that of a confidential or sensitive document that has been processed and then redacted for public release.